

9911

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	c. LENGTH OF STAY IN 1b 30 years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 2001 Virginia Ave.,		d. STREET ADDRESS 2001 Virginia Ave.,	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Catherine Middle V Last Adams		4. DATE OF DEATH Month 9 Day 13 Year 19 57	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 15, 1875
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Frederick Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Dallas Gaver	
14. MOTHER'S MAIDEN NAME Mary Ellen Hessong		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Marion Adams, 2001 Va. Ave. Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Hypertension + Arterio sclerotic Cardiac 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b). Vascular disease with myocardial failure DUE TO (c). PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH 5 yrs +
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Feb 13, 1957 , to 13 Sept 1957 , that I last saw the deceased alive on 13 Sept 1957 , and that death occurred at 12:00 P.M. from the causes and on the date stated above. ADDRESS (street, city or town, state) 2301 Potomac Hagerstown Md. DATE SIGNED 13 Sept 57 ACTUAL SIGNATURE F F Lusby M.D. PHYSICIAN'S NAME (Type) F F Lusby			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9-15-1957	22c. NAME OF CEMETERY OR CREMATORY Rest Haven	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle		ADDRESS Myersville, Md.	24a. REC'D BY REGISTRAR Sept. 16, 1957
24b. REGISTRAR'S SIGNATURE Phyllis Gowers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9949

CERTIFICATE OF DEATH

09908

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown				c. LENGTH OF STAY IN 1b 49 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 24 E. Green St.,				d. STREET ADDRESS 24 E. Green St.,			
3. NAME OF DECEASED (Type or print) First Ira Middle Thurman Last Angle				4. DATE OF DEATH Month 9 Day 9 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 20, 1887	
9. AGE (In years last birthday) 70 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired				10b. KIND OF BUSINESS OR INDUSTRY Victor Products		11. BIRTHPLACE (State or foreign country) Claylick, Penna.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Martin Luther Angle				14. MOTHER'S MAIDEN NAME Amanda C. Hawbaker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-09-7879		17. INFORMANT Address Mrs. Etha Angle Funkstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Arterio-sclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Sept 6, 1957 to Sept 9, 1957 that I last saw the deceased alive on Sept 9, 1957 , and that death occurred at 8:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Funkstown Md. DATE SIGNED 9-11-57							
ACTUAL SIGNATURE SIDNEY NOVENSTEIN				PHYSICIAN'S NAME (Type) SIDNEY NOVENSTEIN			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9-12-57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss ADDRESS Hagerstown, Md.				24a. REC'D BY REGISTRAR Sept. 12, 1957		24b. REGISTRAR'S SIGNATURE Phaeth Bowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 2 File G221 10-7-57 et
9912
CERTIFICATE OF DEATH

09909

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Maudslayi Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		d. STREET ADDRESS 217 North Locust St. Menonite Home	
3. NAME OF DECEASED (Type or print) First Amanda Middle Bailey Last		4. DATE OF DEATH Month 9 Day 24 Year 1957	
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 2, 1874
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) home duties		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob Barncord		14. MOTHER'S MAIDEN NAME Sarah Dennis	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. J. W. Barncord		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443x Cerebral hemorrhage DUE TO (b) Hypertensive cardiovascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH 1 wk, Indefinite
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from April 24, 1951, to Sept. 24, 1957, that I last saw the deceased alive on Sept. 24, 1957, and that death occurred at 2:45 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE B. B. Kneisley M.D.		ADDRESS (Street, city or town, state) 148 West Washington St. DATE SIGNED 9/25/57	
PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		Hagerstown, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 9-27-57	22c. NAME OF CEMETERY OR CREMATORY Broadfording	22d. LOCATION (City, town, or county) (State) Broadfording Md.
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR DATE Sept. 26, 1957		24b. REGISTRAR'S SIGNATURE Robert H. Bowers	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

NAME OF DECEASED JAMES H. BROWN		AGE 45		SEX Male		RACE White		DATE OF BIRTH Jan 15 1912		PLACE OF BIRTH Baltimore, Md.	
MARRIAGE Married		EDUCATION High School		OCCUPATION Clerk		RELIGION Roman Catholic		MILITARY SERVICE None		NAVY SERVICE None	
PLACE OF DEATH Baltimore, Md.		DATE OF DEATH Sep 30 1957		TIME OF DEATH 10:30 AM		CAUSE OF DEATH Myocardial Infarction		MANNER OF DEATH Natural		CERTIFICATE NO. 12345	
SIGNATURE OF DECEASED James H. Brown		SIGNATURE OF WITNESS John Doe		SIGNATURE OF PHYSICIAN Dr. Smith		SIGNATURE OF CORONER Mr. Jones		SIGNATURE OF REGISTRAR Mrs. White		SIGNATURE OF CLERK Miss Green	

BUREAU V. 2

SEP 30 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9913

CERTIFICATE OF DEATH

09910
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) KEEDYSVILLE RURAL X/	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS KEEDYSVILLE MD.R.1	
3. NAME OF DECEASED (Type or print) First Middle Last BABY BOY BAKER		4. DATE OF DEATH Month Day Year SEPTEMBER 8 1957 19	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 8 1957
9. AGE (In years lost birthday) yrs. 2		10. IF UNDER 1 YEAR Months Days Hours Min. 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY HAGERSTOWN WASH.CO.MD.	
11. BIRTHPLACE (State or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME RALPH BAKER		14. MOTHER'S MAIDEN NAME BERNICE ANN REMSBURG	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT RALPH BAKER KEEDYSVILLE MD.R 1.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital heart and 754.4 DUE TO atelectasis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Omphalocele			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 8, 1957 to Sept 8, 1957 that I last saw the deceased alive on Sept. 8, 1957 , and that death occurred at 12 noon from the causes and on the date stated above. ADDRESS (Street, city or town, state) Sept. 9, 1957 DATE SIGNED ACTUAL SIGNATURE F. D. Done M.D. PHYSICIAN'S NAME (Type) Boat Funeral Home			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 9 1957	
22c. NAME OF CEMETERY OR CREMATORY MOUNTAIN VIEW CEMETERY SHARPSBURG WASH.CO.MD.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Boat Funeral Home		24a. REC'D BY REGISTRAR Sept 12, 1957	
24b. REGISTRAR'S SIGNATURE Boat Funeral Home		24c. REGISTRAR'S SIGNATURE Boat Funeral Home	

2081231xv5

CERTIFICATE OF DEATH

9913

NAME OF DECEASED [Faint text, possibly "JOHN J. ..."]		SEX [Faint text, possibly "Male"]	
DATE OF BIRTH [Faint text, possibly "1910 ..."]		PLACE OF BIRTH [Faint text, possibly "Baltimore, Md."]	
OCCUPATION [Faint text, possibly "Carpenter"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
PLACE OF DEATH [Faint text, possibly "Home"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]	
NAME OF PHYSICIAN [Faint text, possibly "Dr. J. H. ..."]		NAME OF FUNERAL HOME [Faint text, possibly "The ..."]	
NAME OF NEXT OF KIN [Faint text, possibly "Mrs. J. H. ..."]		NAME OF MINISTER [Faint text, possibly "Rev. ..."]	
NAME OF BURIAL PLACE [Faint text, possibly "St. ..."]		NAME OF CEMETERY [Faint text, possibly "St. ..."]	
NAME OF INTERVIEWER [Faint text, possibly "Miss ..."]		NAME OF REGISTRAR [Faint text, possibly "Mr. ..."]	

BUREAU V. S.

SEP 18 1957

RECEIVED



THIS CERTIFICATE IS VALID FOR THE PURPOSE OF IDENTIFICATION ONLY. IT IS NOT VALID FOR THE PURPOSE OF IDENTIFICATION OF THE DECEASED. IT IS NOT VALID FOR THE PURPOSE OF IDENTIFICATION OF THE DECEASED. IT IS NOT VALID FOR THE PURPOSE OF IDENTIFICATION OF THE DECEASED.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9914

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 620 North Prospect St.		d. STREET ADDRESS 620 North Prospect St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LIZZIE Middle MAUDE Last BLICKENSTAFF		4. DATE OF DEATH Month Sept. Day 2 Year 19 57	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 30, 1879
9. AGE (In years lost birthday) yrs. 78		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Frederick County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Josephas Palmer		14. MOTHER'S MAIDEN NAME Manzell Rice	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Ray Blume		Address 909 Preston Road Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Vascular Hypertension 331X DUE TO Acute Cerebral Hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None			INTERVAL BETWEEN ONSET AND DEATH 20 yrs 10 days
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour a. m. None 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) (County) (State) - - -
21. I certify that I attended the deceased from July , 19 54 , to Sept. 2 , 19 57 , that I last saw the deceased alive on Sept. 2 , 19 57 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED S. Robert Wells M.D. 115 N. Potomac Street 9-3-57 ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) S. Robert Wells, M.D. Hagerstown, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Sept. 4, 1957	22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. 1601 Penna. Ave. Hagerstown, Md.		24a. REC'D BY REGISTRAR Sept. 3, 1957 24b. REGISTRAR'S SIGNATURE Blanch Bowers	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9915

CERTIFICATE OF DEATH

09912

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 50 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last EFFIE MYRTLE BOWMAN				4. DATE OF DEATH Month Day Year SEPT. 23 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11/22/1872	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME DANIEL R. BURNS				14. MOTHER'S MAIDEN NAME ?? SHUTZ			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. ALVEY B. BOWMAN		18. HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) (1) Diverticulitis of colon (2) mesenteric thrombosis DUE TO (2) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) (c)							INTERVAL BETWEEN ONSET AND DEATH 16 days - 3 years -
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 9/16 19 57 , to 9/23 19 57 , that I last saw the deceased alive on 9/22 19 57 , and that death occurred at 5:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 136 W. Washington St Hagerstown, Md. DATE SIGNED 9/23/57 ACTUAL SIGNATURE George Jennings M.D. PHYSICIAN'S NAME (Type) George Jennings							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/25/57		22c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.				24a. REC'D BY REGISTRAR Sept. 27, 1957		24b. REGISTRAR'S SIGNATURE B. H. Bowers	

• **THE**

BUREAU V. 5

OCT 1 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9916

CERTIFICATE OF DEATH

09913

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 8 Hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				d. STREET ADDRESS 37 Mealey Pkwy		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) PAUL STEWART BOWMAN		First Middle Last		4. DATE OF DEATH Month Day Year September 24 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 28 1922	
9. AGE (In years last birthday) 35 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Office Manager Hag Lumber Corp.		10b. KIND OF BUSINESS OR INDUSTRY Hagerstown Wash. Co		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Frank S. Bowman Sr		14. MOTHER'S MAIDEN NAME Maude E. Stewart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give way or dates of service) W.W.# 2 315-18-1123		17. INFORMANT Address Mrs Ella S. Bowman 37 Mealey Pkwy			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 292.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		Aplastic Anemia		Hagerstown Md.		INTERVAL BETWEEN ONSET AND DEATH 3 mo.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept. 23, 1957 to Sept. 24, 1957 , that I last saw the deceased alive on Sept. 23, 1957 , and that death occurred at 1:10 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 148 West Washington St. 9/25/57							
ACTUAL SIGNATURE B. B. Kneisley		M.D. Hagerstown, Maryland					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/26/57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR Sept. 26, 1957	
						24b. REGISTRAR'S SIGNATURE Shelley Bowers	

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES A. BROWN JR.		2. SEX Male	
3. AGE 35		4. DATE OF BIRTH 1928	
5. PLACE OF BIRTH BALTIMORE, MD		6. OCCUPATION Salesman	
7. MARITAL STATUS Married		8. DATE OF MARRIAGE 1955	
9. NAME OF SPOUSE JAMES A. BROWN SR.		10. DATE OF DEATH 1967	
11. PLACE OF DEATH Home		12. CAUSE OF DEATH Heart Disease	
13. MEDICAL HISTORY Hypertension, Diabetes		14. SIGNATURE OF PHYSICIAN [Signature]	
15. SIGNATURE OF DECEASED [Signature]		16. SIGNATURE OF WITNESSES [Signatures]	
17. SIGNATURE OF REGISTRAR [Signature]		18. OFFICIAL SEAL [Seal]	

BUREAU V. S.

SEP 30 1967

RECEIVED

9917

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital				d. STREET ADDRESS 111 Elizabeth St.,			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) Premature Baby Girl				4. DATE OF DEATH Month 9 Day 9 Year 19 57			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-9-57	
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours Min. 16	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) baby				10b. KIND OF BUSINESS OR INDUSTRY baby		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME Raymond Bussard				14. MOTHER'S MAIDEN NAME Dorothy May Bowman			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Raymond Bussard Address Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 776x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 16 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 9/9/57 , to 9/9/57 , that I last saw the deceased alive on 9/9/57 , and that death occurred at 7:00 PM , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) 3024 Potomac St. Hagerstown Md				DATE SIGNED 9/11/57			
ACTUAL SIGNATURE G.M. Bacon							
PHYSICIAN'S NAME (Type) Fred W. Kraiss							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-11-57		22c. NAME OF CEMETERY OR CREMATORY Broadfording Ch. of God		22d. LOCATION (City, town, or county) (State) Broadfording Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss				ADDRESS Hagerstown, Md.			
24a. RECEIVED BY REGISTRAR Sept. 12, 1957				24b. REGISTRAR'S SIGNATURE Robert E. Spence			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

581254XVO

RECEIVED

SEP 13 1957

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED: WILLIAM H. HARRIS	
2. DATE OF DEATH: SEP 11 1957	
3. PLACE OF DEATH: WILMINGTON, DELAWARE	
4. TIME OF DEATH: 10:00 PM	
5. CAUSE OF DEATH: HEART DISEASE	
6. MANNER OF DEATH: NATURAL	
7. PLACE OF BIRTH: WILMINGTON, DELAWARE	
8. DATE OF BIRTH: SEP 11 1900	
9. SEX: MALE	
10. RACE: WHITE	
11. OCCUPATION: MANAGER	
12. MARITAL STATUS: MARRIED	
13. NAME OF SPOUSE: MARY H. HARRIS	
14. NAME OF PHYSICIAN: DR. J. H. HARRIS	
15. NAME OF FUNERAL HOME: WILMINGTON FUNERAL HOME	
16. NAME OF MINISTER: WILMINGTON METHODIST CHURCH	
17. NAME OF BURIAL PLACE: WILMINGTON CEMETERY	
18. NAME OF INTERMENT: WILMINGTON CEMETERY	
19. NAME OF CEMETERY: WILMINGTON CEMETERY	
20. NAME OF CEMETERY: WILMINGTON CEMETERY	
21. NAME OF CEMETERY: WILMINGTON CEMETERY	
22. NAME OF CEMETERY: WILMINGTON CEMETERY	
23. NAME OF CEMETERY: WILMINGTON CEMETERY	
24. NAME OF CEMETERY: WILMINGTON CEMETERY	
25. NAME OF CEMETERY: WILMINGTON CEMETERY	
26. NAME OF CEMETERY: WILMINGTON CEMETERY	
27. NAME OF CEMETERY: WILMINGTON CEMETERY	
28. NAME OF CEMETERY: WILMINGTON CEMETERY	
29. NAME OF CEMETERY: WILMINGTON CEMETERY	
30. NAME OF CEMETERY: WILMINGTON CEMETERY	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9950

CERTIFICATE OF DEATH

0991432

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clear Spring R # 1				c. LENGTH OF STAY IN 1b 6 Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Broadfording Road				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last ANNIE LAURIE BUSSARD-THOMAS				4. DATE OF DEATH Month Day Year September 15 1957 19			
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept 30 1858	9. AGE (In years at birthday) yrs. 98	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Md. Hagerstown Wash. Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George F. Heyser				14. MOTHER'S MAIDEN NAME Catherine Artz			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs Ora A. Ernst Clearspring Md R # 1			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Sclerosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterial Sclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 yrs. 10 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Clear Spring Md		(County)	(State)	
21. I certify that I attended the deceased from Jan 1, 1952 to Sept 15 1957 , that I last saw the deceased alive on Sept 15 1957 , and that death occurred at 11:00 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE David R. Brewer		M.D.		ADDRESS (Street, city or town, state) Clear Spring Md		DATE/SIGNED 9/18/57	
PHYSICIAN'S NAME (Type) David R. Brewer							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/18/57	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				24a. REC'D BY REGISTRAR SEP 23 1957		24b. REGISTRAR'S SIGNATURE Joseph Murray	

220 23 1957

RECEIVED

9951

CERTIFICATE OF DEATH

Reg. Dist. No. 305

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO				c. LENGTH OF STAY IN 1b 45 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SOUTH MAIN STREET				d. STREET ADDRESS SOUTH MAIN STREET			
3. NAME OF DECEASED (Type or print) First SARAH Middle RUTH Last BUTTS				4. DATE OF DEATH Month SEPT. Day 5 Year 1957			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APRIL 9 1877	
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MIDDLETOWN FRED.CO.MD. U.S.A.	
13. FATHER'S NAME JOHN YOUNKINS				14. MOTHER'S MAIDEN NAME ELIZABETH REEDER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO				16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. JOHN HALLER BOONSBORO MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 59-12	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from Feb 5 , 19 57 , to Sept 5 , 19 57 , that I last saw the deceased alive on Sept 4 , 19 57 , and that death occurred at 9 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE G. W. Hedden				ADDRESS (Street, city or town, state) Boonsboro Md.		DATE SIGNED 9/7/57	
PHYSICIAN'S NAME (Type) G. W. Hedden							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 8 1957		22c. NAME OF CEMETERY OR CREMATORY GREEN HILL CEMETERY		22d. LOCATION (City, town, or county) (State) MARTINSBURG W. VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Paul F. Hume				ADDRESS Boonsboro Md.		24a. REC'D BY REGISTRAR DATE Sept 8 1957	
				24b. REGISTRAR'S SIGNATURE John H. Post			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

DATE _____

SEP

SAV

CONCLUSIONS

BUREAU V. S.

SEP 11 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9918

CERTIFICATE OF DEATH

09917

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown Md.</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washing County Hospital</u> <u>9/5/57</u>				d. STREET ADDRESS <u>112 W. Potomac St.</u>			
3. NAME OF DECEASED (Type or print) First <u>Patsy</u> Middle <u>Ann</u> Last <u>Campbell</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>14</u> Year <u>1957</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 1 1956</u>	
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>14</u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Roy Lacy Campbell</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Belle Ardinger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Mr. Roy Campbell</u>				112 W. Potomac St. Address <u>Williamsport Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atresia of Biliary System (Congenital)</u> 1 yr <u>756.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ascites, Hydrothorax & Anemia</u> 1 week DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Birth</u> , 1956, to <u>9/14/57</u> , that I last saw the deceased alive on <u>9/14/57</u> , 1957, and that death occurred at <u>6:45 PM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. M. Bacon Jr</u>				ADDRESS (Street, city or town, state) <u>302 N. Potomac St. Hagerstown, Md</u>			
PHYSICIAN'S NAME (Type)				DATE SIGNED <u>9/16/57</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 17-57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edith L. Leaf & Church</u>				24a. REC'D BY REGISTRAR <u>Sept. 16/57</u>		24b. REGISTRAR'S SIGNATURE <u>Shirley Bowers</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John A. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>45</i>	
4. DATE OF DEATH <i>Sept 15, 1957</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. DISEASE OR INJURY <i>Coronary Artery Disease</i>		9. MANNER OF DEATH <i>Natural</i>	
10. SIGNATURE OF PHYSICIAN <i>Dr. J. H. Jones</i>		11. SIGNATURE OF WITNESS <i>John A. Smith</i>		12. SIGNATURE OF DECEASED <i>John A. Smith</i>	
13. SIGNATURE OF REGISTRAR <i>John A. Smith</i>		14. SIGNATURE OF CLERK <i>John A. Smith</i>		15. SIGNATURE OF CHIEF OF BUREAU <i>John A. Smith</i>	

BUREAU V. S.

SEP 18 1957

RECEIVED

9919

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1875 Jefferson Blvd.				d. STREET ADDRESS 1875 Jefferson Blvd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Robert Middle Nelson Last Chaney				4. DATE OF DEATH Month 9 Day 19 Year 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-27-1920		9. AGE (In years last birthday) 36 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lay out man		10b. KIND OF BUSINESS OR INDUSTRY Fairchild Aircraft		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Henry M. Chaney				14. MOTHER'S MAIDEN NAME Bertha I Chaney			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W.W. II 217-12-2151		17. INFORMANT Mrs. Mina J. Chaney		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkin's Disease. 201X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.						INTERVAL BETWEEN ONSET AND DEATH 6 1/2 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 13, 1951 , to Sept. 19, 1957 , that I last saw the deceased alive on Sept. 16, 1957 , and that death occurred at 6:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 119 North Potomac St. DATE SIGNED 9-20-57							
ACTUAL SIGNATURE R. A. Bell M.D.				ADDRESS (Street, city or town, state) 119 North Potomac St. DATE SIGNED 9-20-57			
PHYSICIAN'S NAME (Type) R. A. Bell, M. D.				Hagerstown, Maryland.			
22a. BURIAL CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9-22-57		22c. NAME OF CEMETERY OR CREMATORY River View		22d. LOCATION (City, town, or county) (State) Williamsport Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Sept 23, 1957	
						24b. REGISTRAR'S SIGNATURE Chas. Bowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9920

Item 16 Film G220 9-13-57 et

CERTIFICATE OF DEATH

09919

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 18 Hrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. STREET ADDRESS 1201 Hamilton Blvd			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last NELLE PAULINE CLOPPER				4. DATE OF DEATH Month Day Year Sept 5 1957 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 26 1885	
9. AGE (In years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housekeeper				10b. KIND OF BUSINESS OR INDUSTRY ----			
11. BIRTHPLACE (State or foreign country) Hagerstown Wash. Co Md.				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME William O. Clopper				14. MOTHER'S MAIDEN NAME Susan Baker			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) -----				16. SOCIAL SECURITY NO. 217-32-5885			
17. INFORMANT Dr Evelyn C. Luke				Address 1201 Hamilton Blvd			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO 2 yrs. (c) 24 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov 1956 , to Sept 5, 1957 , that I last saw the deceased alive on Sept 5, 1957 , and that death occurred at 10:50 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 214 N. Potomac St. DATE SIGNED Lloyd A. Hoffman M.D.							
ACTUAL SIGNATURE Lloyd A. Hoffman M.D. Hagerstown Md.							
PHYSICIAN'S NAME (Type) Lloyd A. Hoffman Hagerstown Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 9/7/57			
22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery				22d. LOCATION (City, town, or county) (State) Keedysville Wash. Co Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.			
24a. REC'D BY REGISTRAR Sept 9 1957				24b. REGISTRAR'S SIGNATURE Thaddeus			

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		SEX MALE	
DATE OF BIRTH JAN 5 1928		PLACE OF BIRTH MOBILE, ALABAMA	
OCCUPATION MEMBER OF CONGRESS		CAUSE OF DEATH SELF-DEFENSE	
PLACE OF DEATH MOBILE, ALABAMA		DATE OF DEATH APR 4 1968	
NAME OF PHYSICIAN DR. J. H. HARRIS		NAME OF HOSPITAL MOBILE ALABAMA HOSPITAL	
NAME OF FUNERAL HOME JAMES EARL RAY FUNERAL HOME		NAME OF BURIAL PLACE GREENWICH CEMETERY	
NAME OF NEXT OF KIN MISS BEATRICE RAY		NAME OF WITNESS DR. J. H. HARRIS	
NAME OF REGISTRAR JAMES EARL RAY		NAME OF CLERK JAMES EARL RAY	

BUREAU V. S.

SEP 11 1967

RECEIVED

9952

CERTIFICATE OF DEATH

Reg. Dist. No.

306

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Williamsport</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>None</u>		d. STREET ADDRESS <u>38 West Salisbury Street</u>	
3. NAME OF DECEASED (Type or print) First <u>Lydia</u> Middle <u>Sophia</u> Last <u>Cottrill</u>		4. DATE OF DEATH Month <u>September</u> Day <u>23</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 1, 1873</u>
9. AGE (In years last birthday) <u>84</u> yrs.		IF UNDER 1 YEAR Months <u>9</u> Days <u>23</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Pinesburg, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Grove</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Cook</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u>217-80-5567</u>	
17. INFORMANT Address <u>Mrs. Ruth Cottrill Williamsport, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> DUE TO <u></u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 Day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <u></u>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>9/22/57</u> to <u>9/23/57</u> , that I last saw the deceased alive on <u>9/23/57</u> , and that death occurred at <u>9:40</u> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Joseph F. Young</u> M.D.		DATE SIGNED <u>9/24/57</u>	
PHYSICIAN'S NAME (Type) <u></u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/26/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Riverview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Williamsport Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard J. Grove</u>		ADDRESS <u>Hancock Md</u>	
24a. REC'D BY REGISTRAR <u>DATE: Sept. 26-57</u>		24b. REGISTRAR'S SIGNATURE <u>E Lee McChoy</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 8

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9921

CERTIFICATE OF DEATH

09921

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 16 YRS.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 320 W. HOWARD ST.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JOHN Middle RICHARD Last CRIM				4. DATE OF DEATH Month SEPT. Day 18 Year 19 57			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/25/1883	
9. AGE (In years last birthday) 74 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED BOOKKEEPER		10b. KIND OF BUSINESS OR INDUSTRY LUMBER CO. OFFICE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME RUFUS SMITH CRIM		14. MOTHER'S MAIDEN NAME SARAH C. MULL	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) NO		16. SOCIAL SECURITY NO. 180-10-343		17. INFORMANT MISS IDA L. CRIM Address HAGERSTOWN MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonare 026X DUE TO Arterio Sclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebro-Spinal Les DUE TO (c) Arterio Sclerosis						INTERVAL BETWEEN ONSET AND DEATH 3 yrs 6 yrs 30 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan 1, 1953 , to 9-18 , 1957, that I last saw the deceased alive on 9-17 , 1957, and that death occurred at 4:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Robert P. Conrad				ADDRESS (Street, city or town, state) 137 W. Washington		DATE SIGNED 9-18-57	
PHYSICIAN'S NAME (Type) Robert P. Conrad				Hagerstown, Md			
22a. BURIAL, CREMATION, RITUAL (Specify) BURIAL		22b. DATE THEREOF 9/20/57		22c. NAME OF CEMETERY OR CREMATORY BAKERSVILLE CEM.		22d. LOCATION (City, town, or county) (State) WASHINGTON COUNTY MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Normant, Hagerstown, Md.				24a. REG'D BY REGISTRAR Sept. 21, 1957		24b. REGISTRAR'S SIGNATURE Phyllis Bowers	

RECEIVED

SEP 24 1957

BUREAU Y. S.

FEDERAL BUREAU OF INVESTIGATION U. S. DEPARTMENT OF JUSTICE		WASHINGTON, D. C.	
DATE OF BIRTH: [REDACTED]		DATE OF DEATH: [REDACTED]	
PLACE OF BIRTH: [REDACTED]		PLACE OF DEATH: [REDACTED]	
MARRIAGE: [REDACTED]		MARRIAGE: [REDACTED]	
MOTHER: [REDACTED]		MOTHER: [REDACTED]	
FATHER: [REDACTED]		FATHER: [REDACTED]	
SISTER: [REDACTED]		SISTER: [REDACTED]	
BROTHER: [REDACTED]		BROTHER: [REDACTED]	
EDUCATION: [REDACTED]		EDUCATION: [REDACTED]	
OCCUPATION: [REDACTED]		OCCUPATION: [REDACTED]	
MILITARY SERVICE: [REDACTED]		MILITARY SERVICE: [REDACTED]	
CIVIL SERVICE: [REDACTED]		CIVIL SERVICE: [REDACTED]	
REMARKS: [REDACTED]		REMARKS: [REDACTED]	
SIGNATURE: [REDACTED]		SIGNATURE: [REDACTED]	
TITLE: [REDACTED]		TITLE: [REDACTED]	
DATE: [REDACTED]		DATE: [REDACTED]	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9922

CERTIFICATE OF DEATH

09922
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 5 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 RURAL HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 1 RT.#4		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last RACHEL SUSAN DALEY				4. DATE OF DEATH Month Day Year SEPT. 22 19 57			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/9/1880	
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
13. FATHER'S NAME JACOB MYERS				14. MOTHER'S MAIDEN NAME MARGARET BOWARD			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. NONE		17. INFORMANT MR. ANGLE M. DALEY	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x Diabetic Mellitus DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio sclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH year year			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21. I certify that I attended the deceased from 22 Aug 1957 , to 22 Sept 1957 that I last saw the deceased alive on 22 Sept 1957 , and that death occurred at 3:15 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE Elder Woodlark M.D.				ADDRESS (Street, city or town, state) Hagerstown Md			
DATE SIGNED 9/23/57							
PHYSICIAN'S NAME (Type) E. Hoachler							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/24/57		22c. NAME OF CEMETERY OR CREMATORY PLEASANT HILL U.B. CHURCH		22d. LOCATION (City, town, or county) FRANKLIN CO. PENNA.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.				ADDRESS 27.1957		24a. REC'D BY REGISTRAR W. J. Norment	
				24b. REGISTRAR'S SIGNATURE W. J. Norment			

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A1SME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

99223020
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
c. LENGTH OF STAY IN 1b 7 days		d. STREET ADDRESS 2417 Penna Avenue	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle -- Last Davis		4. DATE OF DEATH Month Sept. Day 20 , Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 21, 1891
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months 66 Days 66	IF UNDER 24 HRS. Hours 66 Min. 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Trackman W.M.R.R.		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Yugo slavia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME No record		14. MOTHER'S MAIDEN NAME No record	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. --	
17. INFORMANT Mrs. Blanche Hawbaker-		Address 521 E. Antietam St Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull DUE TO Conditions, if any, which gave rise to immediate cause (b) 812x (c), stating the underlying cause lost. DUE TO (c) 812x			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 7 days			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Pedestrian that was hit by automobile	
20c. TIME OF INJURY Month, Day, Year 4:45 p.m. Sept. 14, 1957	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	20f. (City or town) (County) (State) Hagerstown Wash Md
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-22-57	
22c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery		22d. LOCATION (City, town, or county) (State) Smithsburg, Wash Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR Sept 24 1957		24b. REGISTRAR'S SIGNATURE Shaw/Bowser	

RECEIVED
BUREAU V. S.

SEP 25 1957

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09924

9953

CERTIFICATE OF DEATH

Reg. Dist. No. 301

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport R # 1				c. LENGTH OF STAY IN 1b 68 Yrs			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION near Downsville				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X/ Williamsport R # 1			
				d. STREET ADDRESS near Downsville			
				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last SUSAN SALLY DELLINGER				4. DATE OF DEATH Month Day Year Sept 24 1957 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 15 1884	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State of birth and country) Wash. Co Md.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William H. Dellinger				14. MOTHER'S MAIDEN NAME Mary Slifer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Ruth Dellinger Williamsport R # 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Spontaneous Coronary DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)				INTERVAL BETWEEN ONSET AND DEATH 2 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized Atherosclerosis				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Williamsport				20g. (County) Washington		20h. (State) Md.	
21. I certify that I attended the deceased from May 15 , 19 57 , to Sept. 24 , 19 57 , that I last saw the deceased alive on Sept. 23 , 19 57 , and that death occurred at 1:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Edward W. Ditto				DATE SIGNED 9/25/57			
PHYSICIAN'S NAME (Type) Edward W. Ditto III, M.D., 217 W. Washington St., Hagerstown, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/26/57		22c. NAME OF CEMETERY OR CREMATORY river View Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport Wash. Co Md	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				24. REGISTRAR'S SIGNATURE E. S. McElroy			

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

SEP 26 1957

RECEIVED

9954

CERTIFICATE OF DEATH

09925
305
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MAPLEVILLE				c. LENGTH OF STAY IN 1b 11 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BOONSBORO MD. ROUTE 2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First LAURA Middle GRACE Last DETROW				4. DATE OF DEATH Month SEPTEMBER Day 2 Year 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 5 1883	9. AGE (In years last birthday) 74 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MT. AETNA WASH. CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN HUBERT DETROW				14. MOTHER'S MAIDEN NAME MARION FOLTZ			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. ROSCOE MILLER BOONSBORO MD. R. 2 Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Emboli 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Disease DUE TO (c) Arterio Sclerosis Generalized				INTERVAL BETWEEN ONSET AND DEATH 45 yrs 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug 9 , 1957, to Sept 2 , 1957, that I last saw the deceased alive on Sept 2 , 1957, and that death occurred at 8 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Smithsburg Md DATE SIGNED 9/3/57							
ACTUAL SIGNATURE G. A. Kohler				M.D. Smithsburg Md			
PHYSICIAN'S NAME (Type) G. A. KOHLER							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL SEPT. 5 1957		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY BEAVER CREEK CEMETERY		22d. LOCATION (City, town, or county) (State) BEAVER CREEK WASH. CO MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Beaumont House Boonsboro Md. ADDRESS				24a. REC'D BY REGISTRAR Sept 5 1957 DATE		24b. REGISTRAR'S SIGNATURE John E. Ball	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH			
JAMES EARL RAY		35		M		W		1927		MEMPHIS		TENNESSEE		UNITED STATES		UNITED STATES			
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED	
HEART DISEASE		SUICIDE		LABORER		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		STATE OF DEATH		COUNTRY OF DEATH	
APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES		APRIL 4, 1968		MEMPHIS		MEMPHIS		TENNESSEE		UNITED STATES	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		SINGLE		MARRIED		DIVORCED		WIDOWED	
HEART DISEASE		SUICIDE		LABORER		HIGH SCHOOL		METHODIST		MARRIED		MARRIED		MARRIED		MARRIED		MARRIED	

BUREAU V. 1

APR 9 1968

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland h. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 1			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Nursing Home				d. STREET ADDRESS Mt Etna			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last JESSIE EDITH ENGLISH				4. DATE OF DEATH Month Day Year Sept 9 1957 19			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 4 1870	9. AGE (In years last birthday) 87 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Smith				14. MOTHER'S MAIDEN NAME Mary Fry			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Lillian Wolf 525 Frederick St			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease. 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None.				INTERVAL BETWEEN ONSET AND DEATH Years.			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from May 1, 1957 to Sept. 9, 1957 , that I last saw the deceased alive on Sept. 2, 1957 , and that death occurred at 1:00A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE R. A. Bell				ADDRESS (Street, city or town, state) 119 North Potomac St. Hagerstown, Maryland.			
DATE SIGNED 9-10-57							
PHYSICIAN'S NAME (Type) R. A. Bell, M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/11/57	22c. NAME OF CEMETERY OR CREMATORY Funkstown Cemetery		22d. LOCATION (City, town, or county) Funkstown Wash. Co Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				24a. REC'D BY REGISTRAR Sept. 12, 1957			
				24b. REGISTRAR'S SIGNATURE Chas. Bowers			

BUREAU V. S.

SEP 13 1957

RECEIVED

9955

CERTIFICATE OF DEATH

Reg. Dist. No.

09927
366

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>Anne Arundel Co.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Penmar</u>			c. LENGTH OF STAY IN 1b <u>10 Years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X2 Galesville</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Thomas</u> Last <u>Fifer Jr.</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>16</u> Year <u>19 57</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 2, 1879</u>		9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Oyster Co. Woodfield Fish and</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Fifer Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Mary Bailey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. William Thomas Fifer Jr., Galesville Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>420.1</u> DUE TO (c) <u>420.1</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 Minutes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. <u>19</u>			20d. INJURY OCCURRED White Not while at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>16 Sept</u> 19 <u>57</u> , to <u>16 Sept</u> 19 <u>57</u> , that I last saw the deceased alive on <u>16 Sept</u> 19 <u>57</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Robert A. Fifer</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Blue Ridge Summit, Pa 16 Sept</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/19/57</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Quaker Burying Ground</u>		22d. LOCATION (City, town, or county) (State) <u>Galesville Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter J. Grove</u>				ADDRESS <u>Waynesboro Pa.</u>		24a. REC'D BY REGISTRAR <u>SEP 20 57</u> DATE	
				24b. REGISTRAR'S SIGNATURE <u>W. Beach</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. DATE OF DEATH	
3. COUNTY OF DEATH		4. CITY OF DEATH	
5. STREET OF DEATH		6. HOUSE NO. OF DEATH	
7. NAME OF DECEASED		8. SEX OF DECEASED	
9. AGE OF DECEASED		10. OCCUPATION OF DECEASED	
11. CAUSE OF DEATH		12. MANNER OF DEATH	
13. TIME OF DEATH		14. PLACE OF BURIAL	
15. NAME OF FUNERAL HOME		16. NAME OF MINISTER	
17. NAME OF CLERGYMAN		18. NAME OF CHURCH	
19. NAME OF CEMETERY		20. NAME OF INTERMENT	
21. NAME OF BURIAL		22. NAME OF INTERMENT	
23. NAME OF BURIAL		24. NAME OF INTERMENT	
25. NAME OF BURIAL		26. NAME OF INTERMENT	
27. NAME OF BURIAL		28. NAME OF INTERMENT	
29. NAME OF BURIAL		30. NAME OF INTERMENT	
31. NAME OF BURIAL		32. NAME OF INTERMENT	
33. NAME OF BURIAL		34. NAME OF INTERMENT	
35. NAME OF BURIAL		36. NAME OF INTERMENT	
37. NAME OF BURIAL		38. NAME OF INTERMENT	
39. NAME OF BURIAL		40. NAME OF INTERMENT	
41. NAME OF BURIAL		42. NAME OF INTERMENT	
43. NAME OF BURIAL		44. NAME OF INTERMENT	
45. NAME OF BURIAL		46. NAME OF INTERMENT	
47. NAME OF BURIAL		48. NAME OF INTERMENT	
49. NAME OF BURIAL		50. NAME OF INTERMENT	
51. NAME OF BURIAL		52. NAME OF INTERMENT	
53. NAME OF BURIAL		54. NAME OF INTERMENT	
55. NAME OF BURIAL		56. NAME OF INTERMENT	
57. NAME OF BURIAL		58. NAME OF INTERMENT	
59. NAME OF BURIAL		60. NAME OF INTERMENT	
61. NAME OF BURIAL		62. NAME OF INTERMENT	
63. NAME OF BURIAL		64. NAME OF INTERMENT	
65. NAME OF BURIAL		66. NAME OF INTERMENT	
67. NAME OF BURIAL		68. NAME OF INTERMENT	
69. NAME OF BURIAL		70. NAME OF INTERMENT	
71. NAME OF BURIAL		72. NAME OF INTERMENT	
73. NAME OF BURIAL		74. NAME OF INTERMENT	
75. NAME OF BURIAL		76. NAME OF INTERMENT	
77. NAME OF BURIAL		78. NAME OF INTERMENT	
79. NAME OF BURIAL		80. NAME OF INTERMENT	
81. NAME OF BURIAL		82. NAME OF INTERMENT	
83. NAME OF BURIAL		84. NAME OF INTERMENT	
85. NAME OF BURIAL		86. NAME OF INTERMENT	
87. NAME OF BURIAL		88. NAME OF INTERMENT	
89. NAME OF BURIAL		90. NAME OF INTERMENT	
91. NAME OF BURIAL		92. NAME OF INTERMENT	
93. NAME OF BURIAL		94. NAME OF INTERMENT	
95. NAME OF BURIAL		96. NAME OF INTERMENT	
97. NAME OF BURIAL		98. NAME OF INTERMENT	
99. NAME OF BURIAL		100. NAME OF INTERMENT	

George C. Lee

BUREAU V. 2

SEP 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09928

9925

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Pa.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>10 Days</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charmian</u> <u>75X-9</u>
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>Charmian</u>	
3. NAME OF DECEASED (Type or print) First <u>SANDRA</u> Middle <u>KAY</u> Last <u>FITZ</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>7</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 28, 1948</u>
9. AGE (In years last birthday) yrs. <u>8</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>School</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>	
11. BIRTHPLACE (State or foreign country) <u>Waynesboro Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ray C. Fitz</u>		14. MOTHER'S MAIDEN NAME <u>Betty J. Bowman</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Ray C. Fitz</u>		Address <u>Charmian Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral edema</u> <u>237X</u> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Brain tumor</u> DUE TO (c) <u>Severe hypoxia</u> INTERVAL BETWEEN ONSET AND DEATH <u>Several weeks</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8-30</u> , 19 <u>57</u> , to <u>9-7</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-6</u> , 19 <u>57</u> , and that death occurred at <u>6:45</u> A.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>E. Margaret Sullivan</u>		DATE SIGNED <u>11-29-57</u>	
PHYSICIAN'S NAME (Type) <u>E. Margaret Sullivan</u>		ADDRESS (Street, city or town, state) <u>314 N. Potomac St. Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/9/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Fountaindale</u>	22d. LOCATION (City, town, or county) (State) <u>Fairfield, Adams Pa., R.F.D. 1</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter H. Gove</u>		24. REC'D BY REGISTRAR <u>11-29-57</u>	
ADDRESS <u>Waynesboro Pa.</u>		24b. REGISTRAR'S SIGNATURE <u>Shirley Bowers</u>	

BUREAU V. S.

SEP 11 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9926
CERTIFICATE OF DEATH

09929

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	c. LENGTH OF STAY IN 1b <u>70 years</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>515 Reynolds Ave.</u>		d. STREET ADDRESS <u>1 515 Reynolds Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>Edna</u> Middle <u>Giegas</u> Last		4. DATE OF DEATH Month <u>Sept.</u> Day <u>12</u> Year <u>1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 15, 1886</u>
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Hagerstown Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Aaron Lawrence</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Cross</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give war or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Edward C. Giegas</u>		Address <u>Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease.</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None.</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u> </u> 19 <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>April 12, 1956</u> , to <u>Sept. 12, 1957</u> , that I last saw the deceased alive on <u>Sept. 12, 1957</u> , and that death occurred at <u>1:10 A.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>R. A. Bell</u>		ADDRESS (Street, city or town, state) <u>119 N. Potomac St. Hagerstown Md.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. R. A. Bell</u>		DATE SIGNED <u>September 13, 1957.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-14-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son</u>		ADDRESS <u>Hagerstown Md.</u>	
24a. REC'D BY REGISTRAR <u>Sept. 17, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Phyllis Bowers</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 09930

9927

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE <u>Maryland</u> COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marysburg, Pa.</u> 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hagerstown Hospital</u>		d. STREET ADDRESS <u>75X-3</u>	
3. NAME OF DECEASED (Type or print) First <u>Uriah</u> Middle <u>G</u> Last <u>Guss</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>13</u> Year <u>1957</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 30, 1880</u>
9. AGE (In years lost birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u>11</u> Days <u>13</u>	11. IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Minister</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Muffin, Juniata County</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Guss</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ann Moser</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT <u>Mrs. Elsworth Thomas, Marysburg, Pa.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostate</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of Prostate & Myocardial Infarction</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u></u>	
20c. TIME OF INJURY Month <u></u> Day <u></u> Year <u>19</u> Hour <u>a. p.</u> p. m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>		20f. (City or town) (County) (State) <u></u>	
21. I certify that I attended the deceased from <u>9/13</u> , 19 <u>57</u> , to <u>9/13</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/13</u> , 19 <u>57</u> , and that death occurred at <u>6:40</u> A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>75X-3</u> DATE SIGNED <u>9/15/57</u> ACTUAL SIGNATURE <u>W. O. Brewer</u> M.D. <u>W. O. Brewer</u> PHYSICIAN'S NAME (Type) <u>W. O. Brewer</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9-15-57</u>		22b. DATE THEREOF <u>9-15-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>View</u>		22d. LOCATION (City, town, or county) (State) <u>Marysburg, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. O. Brewer</u>		24a. REC'D BY REGISTRAR <u>Sept. 18, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>W. O. Brewer</u>		24c. REGISTRAR'S SIGNATURE <u>W. O. Brewer</u>	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Reg. No. 10

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

PREVIOUS ILLNESS

PREVIOUS SURGERY

PREVIOUS TRAUMA

PREVIOUS DRUGS

PREVIOUS ALCOHOL

PREVIOUS TOBACCO

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

PREVIOUS OTHER

BUREAU V. 5

SEP 20 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 7 Film G220 9-13-57 et
9928
CERTIFICATE OF DEATH

09931
302
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 18 Hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				d. STREET ADDRESS 634 George St			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last HENRY BLESSING HARTFORD				4. DATE OF DEATH Month Day Year Sept 1 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 14 1894	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machinist				10b. KIND OF BUSINESS OR INDUSTRY Pangborn Corp.		11. BIRTHPLACE (State or foreign country) Md. Hagerstown Wash. Co	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Henry E. Hartford				14. MOTHER'S MAIDEN NAME Lillie M. Shoppert			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or date of service) W.W.# 1				16. SOCIAL SECURITY NO.		17. INFORMANT Claude S. HARTFORD Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocarditis 527.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 3 days Years.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month Day Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan , 19 52 , to Sept , 19 57 , that I last saw the deceased alive on 6 Sept , 19 57 , and that death occurred at 6:00 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Edmund S. Hoachland M.D.				ADDRESS (Street, city or town, state) 115 W. Wash.		DATE SIGNED 9/2/57	
PHYSICIAN'S NAME (Type) Edmund S. Hoachland				Hagerstown			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/5/57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR Sept 6. 1957	
						24b. REGISTRAR'S SIGNATURE Chas. H. Bowers	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN J. BROWN		AGE 45		SEX MALE		RACE WHITE		DATE OF DEATH 1957	
PLACE OF BIRTH NEW YORK		DATE OF BIRTH 1912		MARRIAGE 1935		OCCUPATION CLERK		CAUSE OF DEATH HEART DISEASE	
RESIDENCE 1234 E. BALTIMORE ST.		DATE OF DEATH 1957		MARRIAGE 1935		OCCUPATION CLERK		CAUSE OF DEATH HEART DISEASE	
DATE OF DEATH 1957		MARRIAGE 1935		OCCUPATION CLERK		CAUSE OF DEATH HEART DISEASE		SIGNATURE OF DECEASED JOHN J. BROWN	
DATE OF DEATH 1957		MARRIAGE 1935		OCCUPATION CLERK		CAUSE OF DEATH HEART DISEASE		SIGNATURE OF DECEASED JOHN J. BROWN	

BUREAU V. 21

1957 9 10

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9929
CERTIFICATE OF DEATH

09932

Reg. Dist. No. 52

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural- Myersville 10 X 2.2</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington Co. Hospital</u>				d. STREET ADDRESS <u>Rt. #2 Spruce Run Road</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>DAVID EDWARD HIMES</u>				4. DATE OF DEATH Month Day Year <u>September 16 19 57</u>			
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 23, 1883</u>		9. AGE (In years last birthday) yrs. <u>74</u>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Gen. Laborer</u>		11. BIRTHPLACE (State or foreign country) <u>Frederick Co. Md.</u>	
13. FATHER'S NAME <u>William Himes</u>				14. MOTHER'S MAIDEN NAME <u>Amanda Stottlemeyer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-14-6981</u>		17. INFORMANT Address <u>Mrs. Bertha Finneyfrock, Myersville, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the Pancreas with</u> <u>157X</u> DUE TO <u>generalized metastasis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>4 mo.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3/19</u> , 19 <u>55</u> , to <u>9/16</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/16</u> , 19 <u>57</u> , and that death occurred at <u>4:00 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Charles F. Hess</u> M.D. <u>Smithsburg, Md.</u> <u>9/18/57</u> PHYSICIAN'S NAME (Type) <u>Charles F. Hess</u> <u>Smithsburg, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-19-1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Grosskickles</u>		22d. LOCATION (City, town, or county) (State) <u>Nr. Myersville, Fred. Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Paul F. Bittle</u>				ADDRESS <u>Myersville, Md.</u>		24a. RECEIVED BY REGISTRAR <u>Sept 20, 1957</u>	
				24b. REGISTRAR'S SIGNATURE <u>Shast Bowers</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 5.

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9930

CERTIFICATE OF DEATH

09933

Reg. Dist. No.

303

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport Md RFD 1 X/	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS Falling Waters Road	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle Frederick Last Hornbaker		4. DATE OF DEATH Month Sept. Day 8 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21 1940
9. AGE (In years last birthday) 17 yrs.		IF UNDER 1 YEAR Months 1 Days 17 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY Public School	
11. BIRTHPLACE (State or foreign country) Marlowe W. Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME Ralph Jacob Hornbaker		14. MOTHER'S MAIDEN NAME Mary Margaret Boppe	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mr. Ralph J. Hornbaker		Address Falling Waters Rd Williamsport Md RFD 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon - metastatic 153X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from June , 19 55 , to 8 Sept , 19 57 , that I last saw the deceased alive on 8 Sept , 19 57 , and that death occurred at 3:40 P . M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Paul Haric		ADDRESS (Street, city or town, state) 28 W. Potomac Street Williamsport Maryland	
DATE SIGNED 9 Sept 57			
PHYSICIAN'S NAME (Type) PAUL HARIC M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 10-57	
22c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Albert X Lee of Williamsport, Md		24a. REC'D BY REGISTRAR Sept. 10, 1957	
24b. REGISTRAR'S SIGNATURE Charles H. Bowers			

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

DEPARTMENT OF HEALTH BALTIMORE, MARYLAND		DATE OF DEATH 1957	
NAME OF DECEASED [Faint Name]		SEX [Faint Sex]	
AGE [Faint Age]		RACE [Faint Race]	
PLACE OF BIRTH [Faint Place]		OCCUPATION [Faint Occupation]	
MARITAL STATUS [Faint Status]		CAUSE OF DEATH [Faint Cause]	
DATE OF DEATH [Faint Date]		TIME OF DEATH [Faint Time]	
PLACE OF DEATH [Faint Place]		SIGNATURE OF PHYSICIAN [Faint Signature]	
SIGNATURE OF REGISTRAR [Faint Signature]		SIGNATURE OF WITNESS [Faint Signature]	

BUREAU V. 1

SEP 13 1957

RECEIVED

9931

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
c. LENGTH OF STAY IN 48 years				d. STREET ADDRESS 49 Fairground Ave.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 49 Fairground Ave.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Alice Middle Madeline Last Long				4. DATE OF DEATH Month Sept. Day 16 Year 1957			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 16, 1908	
9. AGE (In years last birthday) 48 yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) presser				10b. KIND OF BUSINESS OR INDUSTRY laundry		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.	
12. CITIZEN OF WHAT COUNTRY? presser							
13. FATHER'S NAME William C. Oden				14. MOTHER'S MAIDEN NAME Anna Barnhart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 219-12-1341			
17. INFORMANT Raymond E. LeFevre, Hagerstown, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Arterio-Sclerotic Hypertension DUE TO Cardio-Vascular Disease with terminal Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion DUE TO (c) Coronary Occlusion PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 54							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 16 Sept 1957 , to 16 Sept 1957 , that I last saw the deceased alive on 16 Sept 1957 , and that death occurred at 4:45 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Frank F. Lusby M.D.				ADDRESS (Street, city or town, state) 230 N. Potomac St., Hagerstown, Md.			
DATE SIGNED 17 Sept 57							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial				22b. DATE THEREOF 9-19-57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
22d. LOCATION (City, town, or county) (State) Hagerstown, Md.							
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.				24a. RECEIVED BY REGISTRAR Sept. 19, 1957			
24b. REGISTRAR'S SIGNATURE Shast H. Brewer							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1931

<p>1. NAME OF DECEASED Alice</p>		<p>2. SEX Female</p>		<p>3. AGE 45 years</p>		<p>4. DATE OF BIRTH May 15, 1886</p>		<p>5. PLACE OF BIRTH Hagerstown, Md.</p>	
<p>6. NAME OF DECEASED Alice</p>		<p>7. SEX Female</p>		<p>8. AGE 45 years</p>		<p>9. DATE OF BIRTH May 15, 1886</p>		<p>10. PLACE OF BIRTH Hagerstown, Md.</p>	
<p>11. NAME OF DECEASED Alice</p>		<p>12. SEX Female</p>		<p>13. AGE 45 years</p>		<p>14. DATE OF BIRTH May 15, 1886</p>		<p>15. PLACE OF BIRTH Hagerstown, Md.</p>	
<p>16. NAME OF DECEASED Alice</p>		<p>17. SEX Female</p>		<p>18. AGE 45 years</p>		<p>19. DATE OF BIRTH May 15, 1886</p>		<p>20. PLACE OF BIRTH Hagerstown, Md.</p>	
<p>21. NAME OF DECEASED Alice</p>		<p>22. SEX Female</p>		<p>23. AGE 45 years</p>		<p>24. DATE OF BIRTH May 15, 1886</p>		<p>25. PLACE OF BIRTH Hagerstown, Md.</p>	
<p>26. NAME OF DECEASED Alice</p>		<p>27. SEX Female</p>		<p>28. AGE 45 years</p>		<p>29. DATE OF BIRTH May 15, 1886</p>		<p>30. PLACE OF BIRTH Hagerstown, Md.</p>	
<p>31. NAME OF DECEASED Alice</p>		<p>32. SEX Female</p>		<p>33. AGE 45 years</p>		<p>34. DATE OF BIRTH May 15, 1886</p>		<p>35. PLACE OF BIRTH Hagerstown, Md.</p>	
<p>36. NAME OF DECEASED Alice</p>		<p>37. SEX Female</p>		<p>38. AGE 45 years</p>		<p>39. DATE OF BIRTH May 15, 1886</p>		<p>40. PLACE OF BIRTH Hagerstown, Md.</p>	
<p>41. NAME OF DECEASED Alice</p>		<p>42. SEX Female</p>		<p>43. AGE 45 years</p>		<p>44. DATE OF BIRTH May 15, 1886</p>		<p>45. PLACE OF BIRTH Hagerstown, Md.</p>	
<p>46. NAME OF DECEASED Alice</p>		<p>47. SEX Female</p>		<p>48. AGE 45 years</p>		<p>49. DATE OF BIRTH May 15, 1886</p>		<p>50. PLACE OF BIRTH Hagerstown, Md.</p>	
<p>51. NAME OF DECEASED Alice</p>		<p>52. SEX Female</p>		<p>53. AGE 45 years</p>		<p>54. DATE OF BIRTH May 15, 1886</p>		<p>55. PLACE OF BIRTH Hagerstown, Md.</p>	
<p>56. NAME OF DECEASED Alice</p>		<p>57. SEX Female</p>		<p>58. AGE 45 years</p>		<p>59. DATE OF BIRTH May 15, 1886</p>		<p>60. PLACE OF BIRTH Hagerstown, Md.</p>	
<p>61. NAME OF DECEASED Alice</p>		<p>62. SEX Female</p>		<p>63. AGE 45 years</p>		<p>64. DATE OF BIRTH May 15, 1886</p>		<p>65. PLACE OF BIRTH Hagerstown, Md.</p>	
<p>66. NAME OF DECEASED Alice</p>		<p>67. SEX Female</p>		<p>68. AGE 45 years</p>		<p>69. DATE OF BIRTH May 15, 1886</p>		<p>70. PLACE OF BIRTH Hagerstown, Md.</p>	
<p>71. NAME OF DECEASED Alice</p>		<p>72. SEX Female</p>		<p>73. AGE 45 years</p>		<p>74. DATE OF BIRTH May 15, 1886</p>		<p>75. PLACE OF BIRTH Hagerstown, Md.</p>	
<p>76. NAME OF DECEASED Alice</p>		<p>77. SEX Female</p>		<p>78. AGE 45 years</p>		<p>79. DATE OF BIRTH May 15, 1886</p>		<p>80. PLACE OF BIRTH Hagerstown, Md.</p>	
<p>81. NAME OF DECEASED Alice</p>		<p>82. SEX Female</p>		<p>83. AGE 45 years</p>		<p>84. DATE OF BIRTH May 15, 1886</p>		<p>85. PLACE OF BIRTH Hagerstown, Md.</p>	
<p>86. NAME OF DECEASED Alice</p>		<p>87. SEX Female</p>		<p>88. AGE 45 years</p>		<p>89. DATE OF BIRTH May 15, 1886</p>		<p>90. PLACE OF BIRTH Hagerstown, Md.</p>	
<p>91. NAME OF DECEASED Alice</p>		<p>92. SEX Female</p>		<p>93. AGE 45 years</p>		<p>94. DATE OF BIRTH May 15, 1886</p>		<p>95. PLACE OF BIRTH Hagerstown, Md.</p>	
<p>96. NAME OF DECEASED Alice</p>		<p>97. SEX Female</p>		<p>98. AGE 45 years</p>		<p>99. DATE OF BIRTH May 15, 1886</p>		<p>100. PLACE OF BIRTH Hagerstown, Md.</p>	

BUREAU V. 3

SEP 23 1957

RECEIVED

Items 8 & 9, Film G221, 10/3/57

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital				d. STREET ADDRESS 54 W. Franklin St.			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Harvey Middle F Last Mellinger				4. DATE OF DEATH Month 9 Day 23 Year 19 57			
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 7, 1885		9. AGE (In years last birthday) 70 6 9 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer		10b. KIND OF BUSINESS OR INDUSTRY General		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 1905-1912		17. INFORMANT Mrs. Ruth Monninger		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 201x Hodgkins Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 201x DUE TO (c)							INTERNAL BETWEEN ONSET AND DEATH 2 1/2 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 1, 1957 , to 23 Sept 1957 , that I last saw the deceased alive on 23 Sept 1957 , and that death occurred at 7³⁰ A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 28 W. Patomac St. Hagerstown, Md. DATE SIGNED 25 Sept 57							
ACTUAL SIGNATURE Paul Harric M.D.				PHYSICIAN'S NAME (Type) PAUL HARRIC, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-27-57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill		22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss ADDRESS Hagerstown, Md.				24a. REC'D BY REGISTRAR Sept. 26 1957		24b. REGISTRAR'S SIGNATURE W. H. Bowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09937

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Sharpsburg			c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Leitersburg			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Taylor's Landing				d. STREET ADDRESS R # 5 Hagerstown		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Edwin Middle Wendell Last Miller				4. DATE OF DEATH Month Sept. Day 1 Year 19 57				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 12, 1906		
9. AGE (In years last birthday) 51 yrs.		IF UNDER 1 YEAR Months 6 Days 19		IF UNDER 24 HRS. Hours Min. 				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Wendell Miller				14. MOTHER'S MAIDEN NAME Edna Conrad				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. W. W. #1 213-03-0949		17. INFORMANT Richard Miller - Hagerstown, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to drowning 850X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) 							INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Drowned when lost balance and fell out of fishing boat					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 5:30 xx Sept. 1st 57			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) River		20f. (City or town) (County) (State) Rural Sharpsburg Wash Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-4-57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home - Hagerstown, Md.				24a. REC'D BY REGISTRAR DATE 9-4-57		24b. REGISTRAR'S SIGNATURE E. G. Boyer		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item PM3. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Birth		Place of Birth		Usual Residence		Cause of Death		Manner of Death		Signature of Examiner		Signature of Coroner		Signature of Physician	
John Doe		Male		45		White		10/10/1912		Baltimore, Md.		1234 Main St.		Heart Disease		Natural		[Signature]		[Signature]		[Signature]	
Occupation		Marital Status		Education		Religion		Date of Death		Place of Death		Time of Death		Temperature		Pulse		Respiration		Blood Pressure		Weight	
Teacher		Married		High School		Catholic		10/15/1957		Home		10:00 AM		98.6		72		18		120/80		170 lbs	
History of Present Illness		History of Past Illness		Family History		Social History		Autopsy		Disposition of Body		Burial		Cremation		Other		Remarks		Remarks		Remarks	
Patient had been ill for several days with chest pain and shortness of breath.		Patient had no previous history of heart disease.		No family history of heart disease.		Patient was a non-smoker and did not drink alcohol.		Autopsy was performed on 10/16/1957.		Body was buried in the family plot at St. Mary's Cemetery.		Cremation was not requested.		Other disposition was not requested.		Remarks: No significant findings at autopsy.		Remarks: No significant findings at autopsy.		Remarks: No significant findings at autopsy.		Remarks: No significant findings at autopsy.	

BUREAU V. 3

SEP 13 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9933 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09938

Reg. Dist. No. **307**

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland				c. LENGTH OF STAY IN 1b 50yrs			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 111 Bloom Alley				d. STREET ADDRESS 111 Bloom Alley			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Leolius Middle (ne) Last Moore				4. DATE OF DEATH Month Sept Day 4 Year 1957			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 4 1889		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR Months Days 	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Janitor		10b. KIND OF BUSINESS OR INDUSTRY Public building		11. BIRTHPLACE (State or foreign country) Georgia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 214-09-0576		17. INFORMANT Irene Moore 408 Suman Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Perforated peptic ulcer with acute peritonitis 540.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO (c) 							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour a. m. none p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) - (County) - (State) -	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) S, Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-7-1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr. Hagerstown Md				24a. REC'D BY REGISTRAR Sept. 9. 1957		24b. REGISTRAR'S SIGNATURE Robert Bowers	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be furnished to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for filing. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

ARKANSAS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Form with multiple sections for recording death statistics, including fields for name, age, sex, race, cause of death, and place of death. The form is mostly blank with some faint markings.

BUREAU V. S.

SEP 11 - 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09939

9934

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 6 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Rural - Sharpsburg	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS R. F. D. #1	
3. NAME OF DECEASED (Type or print) First Middle Last Annie May Myers		4. DATE OF DEATH Month September Day 27 Year 57	
5. SEX female		6. COLOR OR RACE white	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 10, 1884	
9. AGE (In years last birthday) 73 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Marshall		14. MOTHER'S MAIDEN NAME Cornelia Himes	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 202-18-2884	
17. INFORMANT John Edw. Myers Address RFD# 2, Sharpsburg, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 420.1 DUE TO Coronary occlusion and infarct Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) Hypertensive, arteriosclerotic C. V. disease 5 Yrs (c)		INTERVAL BETWEEN ONSET AND DEATH 1 month 5 1/2 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Bilateral hydrothorax.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. 19		20d. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4/12/57, 19, to 9/27/57, 19, that I last saw the deceased alive on 9/26/57, 19, and that death occurred at 5:40 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Walter H. Shealy		M.D. Sharpsburg, Md. DATE SIGNED 9/27/57	
PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/30/57	
22c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Sharpsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Donald Ackles		24a. REC'D BY REGISTRAR DATE 1.1957	
24b. REGISTRAR'S SIGNATURE			

BUREAU V. S.

OCT 4 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9935

CERTIFICATE OF DEATH

09940

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Franklin					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 4½ years					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Homewood Church Home				d. STREET ADDRESS 302 S. Park Street					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First GRACE Middle V. Last MYERS				4. DATE OF DEATH Month September Day 20 Year 1957					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 3, 1882			
9. AGE (In years lost birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 11 Days 17 Hours Min. 		11. BIRTHPLACE (State or foreign country) Mercersburg, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housework				10b. KIND OF BUSINESS OR INDUSTRY					
13. FATHER'S NAME James R. Myers				14. MOTHER'S MAIDEN NAME Alice M. Keefer					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. none		17. INFORMANT Rev. Mark Wagner Address Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1 DUE TO Cashier Mercersburg Prison Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) 								INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19 Month Day Year 				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)				20g. (County)		20h. (State)			
21. I certify that I attended the deceased from 6-1-57 , 19 57 , to 9-20 , 19 57 , that I last saw the deceased alive on 9-10-57 , 19 57 , and that death occurred at 9:30 P.M. , from the causes and on the date stated above.									
ACTUAL SIGNATURE [Signature] M.D. [Signature]				ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED 9/23/57					
PHYSICIAN'S NAME (Type) [Signature]				DATE SIGNED 9/23/57					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/23/1957		22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery		22d. LOCATION (City, town, or county) (State) Mercersburg, Pa.			
23. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Prager				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Sept. 23, 1957			
24b. REGISTRAR'S SIGNATURE [Signature]									

CERTIFICATE OF DEATH

3035

Reg. Code No. 303

PLACE OF DEATH		HOSPITAL		CITY		STATE	
Hollywood Church Home		Hollywood		Hollywood		California	
NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
James H. Jones		Male		70		September 20, 1957	
RACE		COLOR		DATE OF BIRTH		PLACE OF BIRTH	
White		White		October 3, 1887		Hollywood, California	
MARRIAGE		EDUCATION		OCCUPATION		CAUSE OF DEATH	
Married		High School		Retired		Heart Disease	
SPOUSE		FATHER		MOTHER		BLOOD RELATIONSHIP	
Alice H. Jones		John H. Jones		Mary H. Jones		Son	
FATHER'S NAME		MOTHER'S NAME		FATHER'S OCCUPATION		MOTHER'S OCCUPATION	
John H. Jones		Mary H. Jones		Retired		Retired	
FATHER'S DATE OF DEATH		MOTHER'S DATE OF DEATH		FATHER'S PLACE OF BIRTH		MOTHER'S PLACE OF BIRTH	
				Hollywood, California		Hollywood, California	
FATHER'S AGE AT DEATH		MOTHER'S AGE AT DEATH		FATHER'S EDUCATION		MOTHER'S EDUCATION	
				High School		High School	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S MARRIAGE		MOTHER'S MARRIAGE	
Retired		Retired		Married		Married	
FATHER'S DATE OF MARRIAGE		MOTHER'S DATE OF MARRIAGE		FATHER'S MARRIAGE		MOTHER'S MARRIAGE	
				Married		Married	
FATHER'S PLACE OF MARRIAGE		MOTHER'S PLACE OF MARRIAGE		FATHER'S MARRIAGE		MOTHER'S MARRIAGE	
Hollywood, California		Hollywood, California		Married		Married	
FATHER'S OCCUPATION		MOTHER'S OCCUPATION		FATHER'S MARRIAGE		MOTHER'S MARRIAGE	
Retired		Retired		Married		Married	
FATHER'S DATE OF MARRIAGE		MOTHER'S DATE OF MARRIAGE		FATHER'S MARRIAGE		MOTHER'S MARRIAGE	
				Married		Married	
FATHER'S PLACE OF MARRIAGE		MOTHER'S PLACE OF MARRIAGE		FATHER'S MARRIAGE		MOTHER'S MARRIAGE	
Hollywood, California		Hollywood, California		Married		Married	

BUREAU V. 1

SEP 25 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9936

CERTIFICATE OF DEATH

09941

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>				c. LENGTH OF STAY IN 1b <u>8 Hrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Wash. County Hospital</u>				d. STREET ADDRESS <u>210 Frederick St</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>RUSSELL LEE PENTZ</u>				4. DATE OF DEATH Month Day Year <u>Sept 30 1957</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>Nov 19 1896</u>	9. AGE (In years last birthday) <u>60</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Paper Hanger</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (State & foreign country) <u>Cumberland Co Mechanicburg Penna</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Russell I. Pentz</u>				14. MOTHER'S MAIDEN NAME <u>Camilla R. Schultz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-05-4390</u>		17. INFORMANT <u>Russell Jack Pentz</u> Address <u>Maugansville Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic heart disease with angina</u> <u>420.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive cardiovascular disease</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 yr.</u> <u>2 yr.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that I attended the deceased from <u>April 1</u> , 19 <u>57</u> , to <u>Sept. 30</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>Sept. 29</u> , 19 <u>57</u> , and that death occurred at <u>12:40 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>148 West Washington Street</u> DATE SIGNED <u>9/30/57</u>							
ACTUAL SIGNATURE <u>B. B. Kneisley</u>		M.D. <u>Hagerstown, Maryland</u>					
PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/2/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Hagerstown Wash. Co Md.</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Andrew K. Coffman</u>				ADDRESS <u>Hagerstown Md.</u>		24a. REC'D BY REGISTRAR <u>Oct. 3, 1957</u>	24b. REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>

CERTIFICATE OF DEATH

1930

1. NAME OF DECEASED JAMES H. HARRIS		2. SEX Male		3. AGE 65	
4. DATE OF DEATH October 7, 1930		5. TIME OF DEATH 10:30 AM		6. PLACE OF DEATH Home	
7. CAUSE OF DEATH Heart Disease		8. DISEASE OR INJURY Coronary Artery Disease		9. PRESENT ILLNESS Angina Pectoris	
10. OCCASION OF DEATH Sudden		11. PLACE OF BIRTH Maryland		12. DATE OF BIRTH September 10, 1865	
13. NAME OF MOTHER Mary Harris		14. NAME OF FATHER John Harris		15. NAME OF SPOUSE Elizabeth Harris	
16. NAME OF PHYSICIAN Dr. J. H. Smith		17. NAME OF NURSE Mrs. J. H. Smith		18. NAME OF MINISTER Rev. J. H. Smith	
19. NAME OF BURIAL PLACE St. John's Church		20. NAME OF CEMETERY St. John's Cemetery		21. NAME OF FUNERAL HOME St. John's Funeral Home	
22. NAME OF CORONER J. H. Smith		23. NAME OF JURY J. H. Smith		24. NAME OF WITNESSES J. H. Smith	
25. NAME OF REGISTRAR J. H. Smith		26. NAME OF CLERK J. H. Smith		27. NAME OF ASSISTANT J. H. Smith	
28. NAME OF DEPUTY REGISTRAR J. H. Smith		29. NAME OF DEPUTY CLERK J. H. Smith		30. NAME OF DEPUTY ASSISTANT J. H. Smith	
31. NAME OF DEPUTY REGISTRAR J. H. Smith		32. NAME OF DEPUTY CLERK J. H. Smith		33. NAME OF DEPUTY ASSISTANT J. H. Smith	
34. NAME OF DEPUTY REGISTRAR J. H. Smith		35. NAME OF DEPUTY CLERK J. H. Smith		36. NAME OF DEPUTY ASSISTANT J. H. Smith	
37. NAME OF DEPUTY REGISTRAR J. H. Smith		38. NAME OF DEPUTY CLERK J. H. Smith		39. NAME OF DEPUTY ASSISTANT J. H. Smith	
40. NAME OF DEPUTY REGISTRAR J. H. Smith		41. NAME OF DEPUTY CLERK J. H. Smith		42. NAME OF DEPUTY ASSISTANT J. H. Smith	
43. NAME OF DEPUTY REGISTRAR J. H. Smith		44. NAME OF DEPUTY CLERK J. H. Smith		45. NAME OF DEPUTY ASSISTANT J. H. Smith	
46. NAME OF DEPUTY REGISTRAR J. H. Smith		47. NAME OF DEPUTY CLERK J. H. Smith		48. NAME OF DEPUTY ASSISTANT J. H. Smith	
49. NAME OF DEPUTY REGISTRAR J. H. Smith		50. NAME OF DEPUTY CLERK J. H. Smith		51. NAME OF DEPUTY ASSISTANT J. H. Smith	
52. NAME OF DEPUTY REGISTRAR J. H. Smith		53. NAME OF DEPUTY CLERK J. H. Smith		54. NAME OF DEPUTY ASSISTANT J. H. Smith	
55. NAME OF DEPUTY REGISTRAR J. H. Smith		56. NAME OF DEPUTY CLERK J. H. Smith		57. NAME OF DEPUTY ASSISTANT J. H. Smith	
58. NAME OF DEPUTY REGISTRAR J. H. Smith		59. NAME OF DEPUTY CLERK J. H. Smith		60. NAME OF DEPUTY ASSISTANT J. H. Smith	
61. NAME OF DEPUTY REGISTRAR J. H. Smith		62. NAME OF DEPUTY CLERK J. H. Smith		63. NAME OF DEPUTY ASSISTANT J. H. Smith	
64. NAME OF DEPUTY REGISTRAR J. H. Smith		65. NAME OF DEPUTY CLERK J. H. Smith		66. NAME OF DEPUTY ASSISTANT J. H. Smith	
67. NAME OF DEPUTY REGISTRAR J. H. Smith		68. NAME OF DEPUTY CLERK J. H. Smith		69. NAME OF DEPUTY ASSISTANT J. H. Smith	
70. NAME OF DEPUTY REGISTRAR J. H. Smith		71. NAME OF DEPUTY CLERK J. H. Smith		72. NAME OF DEPUTY ASSISTANT J. H. Smith	
73. NAME OF DEPUTY REGISTRAR J. H. Smith		74. NAME OF DEPUTY CLERK J. H. Smith		75. NAME OF DEPUTY ASSISTANT J. H. Smith	
76. NAME OF DEPUTY REGISTRAR J. H. Smith		77. NAME OF DEPUTY CLERK J. H. Smith		78. NAME OF DEPUTY ASSISTANT J. H. Smith	
79. NAME OF DEPUTY REGISTRAR J. H. Smith		80. NAME OF DEPUTY CLERK J. H. Smith		81. NAME OF DEPUTY ASSISTANT J. H. Smith	
82. NAME OF DEPUTY REGISTRAR J. H. Smith		83. NAME OF DEPUTY CLERK J. H. Smith		84. NAME OF DEPUTY ASSISTANT J. H. Smith	
85. NAME OF DEPUTY REGISTRAR J. H. Smith		86. NAME OF DEPUTY CLERK J. H. Smith		87. NAME OF DEPUTY ASSISTANT J. H. Smith	
88. NAME OF DEPUTY REGISTRAR J. H. Smith		89. NAME OF DEPUTY CLERK J. H. Smith		90. NAME OF DEPUTY ASSISTANT J. H. Smith	
91. NAME OF DEPUTY REGISTRAR J. H. Smith		92. NAME OF DEPUTY CLERK J. H. Smith		93. NAME OF DEPUTY ASSISTANT J. H. Smith	
94. NAME OF DEPUTY REGISTRAR J. H. Smith		95. NAME OF DEPUTY CLERK J. H. Smith		96. NAME OF DEPUTY ASSISTANT J. H. Smith	
97. NAME OF DEPUTY REGISTRAR J. H. Smith		98. NAME OF DEPUTY CLERK J. H. Smith		99. NAME OF DEPUTY ASSISTANT J. H. Smith	
100. NAME OF DEPUTY REGISTRAR J. H. Smith		101. NAME OF DEPUTY CLERK J. H. Smith		102. NAME OF DEPUTY ASSISTANT J. H. Smith	

RECEIVED
OCT 7 1937
BUREAU V. 3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09942

Reg. Dist. No. 302

9937

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>D.O.A.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>						
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				d. STREET ADDRESS <u>1109 Virginia Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>John</u> First <u>Robert</u> Middle <u>Potts, Sr.</u> Last				4. DATE OF DEATH Month <u>September</u> Day <u>15</u> Year <u>19 57</u>						
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 1, 1912</u>		9. AGE (In years last birthday) <u>44</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>14</u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Grocerman</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>own business</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Harry W. Potts</u>				14. MOTHER'S MAIDEN NAME <u>Grace Summers</u>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-30-9143</u>		17. INFORMANT Address <u>Mrs. Hester M. Potts</u> <u>Hagerstown, Maryland</u>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic coronary heart disease</u> DUE TO <u>acute coronary thrombosis</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (a), stating the underlying cause lost. DUE TO (c) <u> </u>								INTERVAL BETWEEN ONSET AND DEATH <u> </u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>None</u>								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u> </u>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>none</u>							
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a. m. <u>none</u> 19 <u> </u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>				
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>										
ACTUAL SIGNATURE <u>S. Robert Wells</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>9-16-57</u>		
EXAMINER'S NAME (Type) <u>S. Robert Wells, M.D.</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>								
22b. DATE THEREOF <u>9/18/1957</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>				22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Maryland</u>				
23. FUNERAL DIRECTOR'S SIGNATURE <u>Suter-Rouzer Funeral Home</u> <u>R. Suter-Rouzer</u>				ADDRESS <u>Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Sept. 18, 1957</u>		24b. REGISTRAR'S SIGNATURE <u>Chas. H. Bowers</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

STATE OF MARYLAND - BALTIMORE 15

1957 SEP 20

Name of Deceased		Age		Sex		Race		Marital Status		Occupation	
Robert		37		Male		White		Married		None	
Date of Death		Place of Death		Cause of Death		Manner of Death		Disease or Injury		Signature of Examiner	
September 1, 1957		Home		Heart Failure		Natural		Coronary Artery Disease		[Signature]	
Time of Death		Place of Burial		Burial		Burial		Burial		Burial	
10:15 AM		Catholic Cemetery		Buried		Buried		Buried		Buried	
Date of Report		Signature of Physician		Signature of Coroner		Signature of Medical Examiner		Signature of Registrar		Signature of Clerk	
September 1, 1957		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. 2

SEP 20 1957

RECEIVED

SEP 20 1957

9957

CERTIFICATE OF DEATH

09943

Reg. Dist. No. 300

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SHARPSBURG				c. LENGTH OF STAY IN 1b 35 YEARS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 120 ANTIETAM ST.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First IRENE Middle C Last PRY				4. DATE OF DEATH Month SEPT. Day 11 Year 1957			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEBRUARY 10 1864	9. AGE (In years last birthday) 93 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) KEEDYSVILLE WASH.CO.MD. U.S.A.		
13. FATHER'S NAME ALFRED COST			14. MOTHER'S MAIDEN NAME MARY BOVEY				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MISS NAOMI NUNAMAKER SHARPSBURG MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized arteriosclerosis 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH 8 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 11 , 19 57 , to Sept 11 , 19 57 , that I last saw the deceased alive on Sept 11 , 19 57 , and that death occurred at 6 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Boonsboro Md. DATE SIGNED 6/13/57							
ACTUAL SIGNATURE G.W. LeVan M.D. Boonsboro Md.							
PHYSICIAN'S NAME (Type) G.W. LeVan							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 14 1957		22c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CEMETERY		22d. LOCATION (City, town, or county) (State) KEEDYSVILLE WASH.CO.MD.	
23. FUNERAL DIRECTOR'S SIGNATURE East Funeral Home Boonsboro Md.				24a. REC'D BY REGISTRAR DATE Sept 17 57		24b. REGISTRAR'S SIGNATURE E. G. Boyer	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. PLACE OF DEATH
 a. CITY
 b. COUNTY
 c. STATE

2. DECEASED
 a. NAME
 b. SEX
 c. AGE
 d. RACE
 e. OCCUPATION

3. DEATH
 a. DATE
 b. TIME
 c. PLACE
 d. CAUSE
 e. MANNER

4. MEDICAL HISTORY
 a. PREVIOUS ILLNESS
 b. PREVIOUS SURGERY
 c. PREVIOUS TRAUMA
 d. PREVIOUS DRUGS
 e. PREVIOUS ALCOHOL

5. SOCIAL HISTORY
 a. OCCUPATION
 b. EDUCATION
 c. RELIGION
 d. MARITAL STATUS
 e. SMOKING HABIT

6. FAMILY HISTORY
 a. PARENTS
 b. SIBLINGS
 c. SPOUSE
 d. CHILDREN

7. SIGNATURES
 a. DECEASED
 b. WITNESSES
 c. PHYSICIAN
 d. CORONER

BUREAU V. S.

SEP 19 1957

RECEIVED

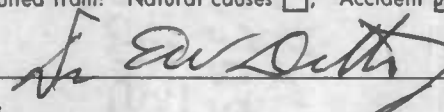
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09944

Reg. Dist. No. 302

9958

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 1 DAY d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL HAGERSTOWN x2 d. STREET ADDRESS RT. #2 HAGERSTOWN e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print) First Middle Last CHARLES WILLIAM RANKIN				4. DATE OF DEATH Month Day Year SEPT. 28 19 57													
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/2/1887		9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY SAND CO.				11. BIRTHPLACE (State or foreign country) WEST VIRGINIA				12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME JOSEPH RANKIN						14. MOTHER'S MAIDEN NAME MARY SHERLEY											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES				16. SOCIAL SECURITY NO. W.W.#1				17. INFORMANT MRS. SUVINA RANKIN RT. #2 HAGERSTOWN MD.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing injury of chest DUE TO 825x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Subcutaneous and mediastinal emphysema DUE TO (c) Cardiac contusion INTERVAL BETWEEN ONSET AND DEATH 12 hours																	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was in auto accident													
20c. TIME OF INJURY Month, Day, Year Hour 11:55 p.m. Sept. 27, 1957				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Route 40 West Hagerstown, Washington, Md.											
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>																	
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
DATE SIGNED Sept. 30, 1957																	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 10/1/1957				22c. NAME OF CEMETERY OR CREMATORY BETHEL CEM.				22d. LOCATION (City, town, or county) (State) MORGAN CO. W. VA.					
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.						24a. REC'D. BY REGISTRAR Oct 1, 1957						24b. REGISTRAR'S SIGNATURE Chas. H. Bowers					

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF DEATH	
JAMES EARL RAY		MALE		35		APRIL 4, 1968	
PLACE OF DEATH		CITY		STATE		COUNTRY	
FEDERAL BUREAU OF INVESTIGATION		WASHINGTON, D.C.		DISTRICT OF COLUMBIA		UNITED STATES OF AMERICA	
OCCUPATION		PROSECUTOR		PROSECUTOR		PROSECUTOR	
CAUSE OF DEATH		FIRE		FIRE		FIRE	
MANNER OF DEATH		SUICIDE		SUICIDE		SUICIDE	
SIGNATURE OF EXAMINER		JAMES EARL RAY		JAMES EARL RAY		JAMES EARL RAY	
DATE OF EXAMINATION		APRIL 4, 1968		APRIL 4, 1968		APRIL 4, 1968	
PLACE OF EXAMINATION		FEDERAL BUREAU OF INVESTIGATION		WASHINGTON, D.C.		DISTRICT OF COLUMBIA	
OCCUPATION OF EXAMINER		PROSECUTOR		PROSECUTOR		PROSECUTOR	
CAUSE OF DEATH		FIRE		FIRE		FIRE	
MANNER OF DEATH		SUICIDE		SUICIDE		SUICIDE	

Handwritten signature and initials

RECEIVED
OCT 4 1967
BUREAU V. 2

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 9938 CERTIFICATE OF DEATH

09945

Reg. Dist. No. 302

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN, MD.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON CO. HOSPITAL		d. STREET ADDRESS 1 136 FAIRGROUND AVE.	
3. NAME OF DECEASED (Type or print) First MELCHORA Middle MAE Last RENNER		4. DATE OF DEATH Month SEPT. Day 7 Year 19 57	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH NOV. 30, 1896
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 10 Days 10 Hours 10 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOME DUTIES		10b. KIND OF BUSINESS OR INDUSTRY NONE	
11. BIRTHPLACE (State or foreign country) ST. PAULS, MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH MELCHOR HARSH		14. MOTHER'S MAIDEN NAME SUSAN MYERS	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-34-1190	
17. INFORMANT MRS HAZEL GROVE		18. ADDRESS 136 FAIRGROUND AVE HAGERSTOWN, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic Pancreatitis 587.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Cholelithiasis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Sept 5, 1957 to Sept 7, 1957 , that I last saw the deceased alive on Sept 6, 1957 , and that death occurred at 8:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE David R. Brewer M.D.		ADDRESS (Street, city or town, state) Box 166 DATE SIGNED 9/7/57	
PHYSICIAN'S NAME (Type) David R. Brewer		Clear Spring Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF SEPT. 10, 1957	22c. NAME OF CEMETERY OR CREMATORY ST. PAULS CEM.	22d. LOCATION (City, town, or county) (State) WASHINGTON CO. MD. WESTERN PIKE ROUTE 40
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark		ADDRESS CLEAR SPRING, MD.	
24a. REC'D BY REGISTRAR Sept 11 1957		24b. REGISTRAR'S SIGNATURE Brewer	

09946

9939

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN lb 3 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) x2 Williamsport (Mt. Tamm,ny)			
f. STREET ADDRESS Hampton Rd. West				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last CLEVER MC KEE REYNOLDS				4. DATE OF DEATH Month Day Year September 30 1957			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 5, 1898	9. AGE (In years last birthday) 58 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 11 25	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Vocational Instructor for Males				10b. KIND OF BUSINESS OR INDUSTRY Maryland Ref.		11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME James M. Reynolds			
14. MOTHER'S MAIDEN NAME Lulu B. Snavelly				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no			
16. SOCIAL SECURITY NO. 214-09-1784				17. INFORMANT Address Mrs. Thelma V. Reynolds Mt. Tammany			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerotic heart disease DUE TO (c) with old Infarction							INTERVAL BETWEEN ONSET AND DEATH 30 min 11 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Benign prostatic Hypertrophy							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I attended the deceased from Aug 1, 1955 , to Sept 30, 1957 , that I last saw the deceased alive on Sept. 29, 1957 , and that death occurred at 8:15 M, from the causes and on the date stated above.							21. ADDRESS (Street, city or town, state) DATE SIGNED 217 W. Washington St. Hagerstown Md. 10/1/57
ACTUAL SIGNATURE Edward W. Ditto II				M.D. 217 W. Washington St. Hagerstown Md.			
PHYSICIAN'S NAME (Type) Edward W. Ditto II, M.D.				217 W. Washington St. Hagerstown Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/3/1957	22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	22d. LOCATION (City, town, or county)	(State)			
22e. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Boyer				ADDRESS Hagerstown, Md.	24a. REC'D BY REGISTRAR Oct. 2, 1957	24b. REGISTRAR'S SIGNATURE Shall Bowers	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS

Reg. No. 100-10000

1957

DATE OF DEATH

WILLIAM

WILLIAM

WILLIAM

WILLIAM (Son of)

WILLIAM

WILLIAM (Son of)

WILLIAM (Son of)

WILLIAM (Son of)

WILLIAM (Son of)

WILLIAM (Son of)

WILLIAM (Son of)

WILLIAM (Son of)

WILLIAM (Son of)

WILLIAM (Son of)

WILLIAM (Son of)

WILLIAM (Son of)

WILLIAM (Son of)

WILLIAM (Son of)

WILLIAM (Son of)

WILLIAM (Son of)

WILLIAM (Son of)

WILLIAM (Son of)

BUREAU V. 8

OCT 4 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9959

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09947 304
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Allegany			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Near Hancock, Md				c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frostburg 0122.2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Along Potomac River while fishing				d. STREET ADDRESS 240 Centre Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First BURDETT Middle SELDON Last ROBERTSON				4. DATE OF DEATH Month Sept. Day 7 Year 1957			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Sept. 16, 1907	
9. AGE (In years last birthday) 49 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Floor covering installation				10b. KIND OF BUSINESS OR INDUSTRY Self employed		11. BIRTHPLACE (State or foreign country) Port Royal, Penna.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Herbert G. Robertson				14. MOTHER'S MAIDEN NAME Anna Smith			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 204-03-8198		17. INFORMANT Harold Potts, Central Ave., Cumberland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. None p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE S. Robert Wells M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) S. Robert Wells, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/10/57		22c. NAME OF CEMETERY OR CREMATORY Fairview Christian Cem.		22d. LOCATION (City, town, or county) (State) Artemas, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE John J. Hafer, Cumberland, Maryland				24a. REC'D BY REGISTRAR SEP 13 1957 DATE			
				24b. REGISTRAR'S SIGNATURE J. H. Kelly			

BUREAU V. 3.

SEP 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 3 and 4 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9940

CERTIFICATE OF DEATH

09948
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 1046 Georgia Ave		d. STREET ADDRESS 1046 Georgia Ave	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First THEADORE M Middle BENJAMIN Last SECORD		4. DATE OF DEATH Month Sept Day 27 Year 1957	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5 1895
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months 62 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Plasterer		10b. KIND OF BUSINESS OR INDUSTRY Retired	
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Secord		14. MOTHER'S MAIDEN NAME Elizabeth (last name unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 220-09-7717	
17. INFORMANT Mrs Viola Secord		Address 1046 Georgia Ave Hagerstown Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of prostate with generalized metastases 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 7 yrs. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Anemia			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 1950 , to 27 Sept 1957 , that I last saw the deceased alive on 27 Sept 1957 , and that death occurred at 3 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 1135 Potomac Ave Hagerstown, Md. DATE SIGNED 27 Sept 1957			
ACTUAL SIGNATURE Richard T. Binford M.D.			
PHYSICIAN'S NAME (Type) Richard T. Binford M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/30/57	
22c. NAME OF CEMETERY OR CREMATORY Funkstown cemetery		22d. LOCATION (City, town, or county) (State) Funkstown Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown Md.	
24a. REC'D BY REGISTRAR Sept 30, 1957		24b. REGISTRAR'S SIGNATURE Blanch Hoover	

CERTIFICATE OF DEATH

PLACE OF BIRTH		DATE OF BIRTH		SEX		RACE	
BALTIMORE, MARYLAND		JAN 1 1901		MALE		WHITE	
MARRIED		DATE OF MARRIAGE		OCCUPATION		EDUCATION	
MARRIED		JAN 1 1901		LABORER		HIGH SCHOOL	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
JAN 1 1901		BALTIMORE, MARYLAND		HEART DISEASE		NATURAL	
DATE OF INTERMENT		PLACE OF INTERMENT		NAME OF FUNERAL HOME		NAME OF MINISTER	
JAN 1 1901		BALTIMORE, MARYLAND		J. J. JONES		J. J. JONES	
DATE OF REPORT		PLACE OF REPORT		NAME OF REPORTER		SIGNATURE	
JAN 1 1901		BALTIMORE, MARYLAND		J. J. JONES		J. J. JONES	

BUREAU V. 1

OCT 2 1957

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9941

CERTIFICATE OF DEATH

09949
 Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 7 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				e. STREET ADDRESS 426 East Franklin st			
f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last EMMA FLORENCE SEMLER				4. DATE OF DEATH Month Day Year Sept 7 1957 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar 4 1875	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Frederick County Va.	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME Christian Shirley				14. MOTHER'S MAIDEN NAME Rhoda Adams			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Dorothy H. Semler 122 E. Antietam St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral vascular accident DUE TO (c) Intermediary				INTERVAL BETWEEN ONSET AND DEATH 1 wk 1 year Unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 904.9 Fracture of hip				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Nat while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Hagerstown				20g. (County) Washington		20h. (State) Md.	
21. I certify that I attended the deceased from Dec 18 , 19 54 , to Sept 7 , 19 57 , that I last saw the deceased alive on Sept 7 , 19 57 , and that death occurred at 7:00 P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED L. L. Packer, Jr.							
ACTUAL SIGNATURE L. L. Packer, Jr.				M.D. Hagerstown, Md.			
PHYSICIAN'S NAME (Type) L. L. Packer, Jr. M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-10-57		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Wash. Co Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Hoffman				ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR Sept. 12, 1957	
						24b. REGISTRAR'S SIGNATURE Chas. Bowers	

SEP 13 1957

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

BALTIMORE, 18										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
Reg. Dist. No. 09950 302										
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mass. b. COUNTY Bristol					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown			c. LENGTH OF STAY IN 1b 1 day		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) New Bedford 58x-3			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) U.S. Rt 11 south					d. STREET ADDRESS 693 Shawmut Ave.					
3. NAME OF DECEASED (Type or print) FRANK MEDEIROS SENNA, JR.					4. DATE OF DEATH Month September Day 5 Year 1957					
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 22, 1916		9. AGE (in years last birthday) 41 yrs.		
								IF UNDER 1 YEAR Months 7 Days 13		
								IF UNDER 24 HRS. Hours Min. 		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Kitchen Help				10b. KIND OF BUSINESS OR INDUSTRY Restraunt		11. BIRTHPLACE (State or foreign country) New Bedford, Mass.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Frank M. Senna, Sr.					14. MOTHER'S MAIDEN NAME unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. Korean 016-01-2495		17. INFORMANT R. Franklin Rouzer		Address Hagerstown, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 353.3 Undetermined as yet DUE TO Aspiration of vomitus Conditions, if any, which gave rise to immediate cause (b) Massive hemorrhage from lungs (c) Probably died during convulsive seizure DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none								INTERVAL BETWEEN ONSET AND DEATH 		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. None				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None						
20c. TIME OF INJURY Month, Day, Year Hour a. m. None p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) -		(County) - (State) -		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .										
ACTUAL SIGNATURE S. Robert Wells					M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type) S. Robert Wells, M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/10/1957		22c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		22d. LOCATION (City, town, or county) (State) Arlington, Virginia				
23. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Rouzer					ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Sept. 11, 1957		24b. REGISTRAR'S SIGNATURE Shast. Rouzer	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Race		Date of Death	
John A. Jones		Male		45		White		10-15-1957	
Address		City		County		State		Manner of Death	
123 Main St.		Baltimore		Baltimore		Maryland		Natural	
Cause of Death		Immediate Cause		Underlying Cause		Contributing Cause		Manner of Death	
Heart Disease		Myocardial Infarction		Coronary Atherosclerosis		Hypertension		Natural	
Date of Autopsy		Time of Autopsy		Place of Autopsy		Signature of Examiner		Signature of Coroner	
10-16-1957		10:00 AM		Baltimore		J. A. Jones		J. A. Jones	

RECEIVED
 SEP 13 1957
 BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 could be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
9961 CERTIFICATE OF DEATH

09951
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Wash.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maugansville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>x2 Maugansville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Maugansville, Md.</u>		d. STREET ADDRESS <u>1 Maugansville, Md</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>FANNIE Ebersole Shanks</u>		4. DATE OF DEATH Month Day Year <u>Sept. 23 1957</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/6/1866</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Clearspring, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Abram Ebersole</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Horst</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. Leroy Martin - Maugansville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.0</u> DUE TO <u>arterio-sclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>10 yrs</u> DUE TO (c) <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>7-1-55</u> , 19 <u>55</u> , to <u>9-23</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9-20-57</u> , 19 <u>57</u> , and that death occurred at <u>2:30 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Chambersburg, Pa.</u> DATE SIGNED <u>9/23/57</u>			
ACTUAL SIGNATURE <u>A. E. W. Dittus</u> M.D.		DATE SIGNED <u>9/23/57</u>	
PHYSICIAN'S NAME (Type) <u>A. E. W. Dittus</u>		DATE SIGNED <u>9/23/57</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/25/57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Memorial Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Chambersburg, Pa.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Mannich</u> ADDRESS <u>Greencastle Pa.</u>		24a. REC'D BY REGISTRAR <u>Sept. 23, 1957</u> 24b. REGISTRAR'S SIGNATURE <u>Phyllis Boers</u>	

CERTIFICATE OF DEATH

1957

NAME OF DECEASED: [illegible]
AGE: [illegible]
SEX: [illegible]
RACE: [illegible]
DATE OF BIRTH: [illegible]
PLACE OF BIRTH: [illegible]
DATE OF DEATH: [illegible]
PLACE OF DEATH: [illegible]
CAUSE OF DEATH: [illegible]
MANNER OF DEATH: [illegible]
SIGNATURE OF PHYSICIAN: [illegible]
SIGNATURE OF REGISTRAR: [illegible]

BUREAU V. E.

SEP 25 1957

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

305

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LOCUST GROVE		c. LENGTH OF STAY IN lb 72 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) LOCUST GROVE RURAL			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION ROHRERSVILLE MD.R.1				d. STREET ADDRESS ROHRERSVILLE MD.R.1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First EMMA		Middle ALICE		Last SMITH	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JANUARY 22 1866	
9. AGE (In years last birthday) 91 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) TREGO WASH.CO.MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME NO RECORD				14. MOTHER'S MAIDEN NAME SOPHIA ROHRER DICK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT IRA J. STINE ROHRERSVILLE WASH.CO.MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis DUE TO (c) cerebral embolus		INTERVAL BETWEEN ONSET AND DEATH 10 yrs 1 day					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from September 15, 1957 to Sept 16, 1957 , that I last saw the deceased alive on Sept 16, 1957 , and that death occurred at 6 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Brownsville Md DATE SIGNED 9/18/57 ACTUAL SIGNATURE G. W. L. Van M.D. PHYSICIAN'S NAME (Type) G. W. L. Van							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF SEPT. 19 1957		22c. NAME OF CEMETERY OR CREMATORY LOCUST GROVE CEMETERY		22d. LOCATION (City, town, or county) (State) LOCUST GROVE WASH.CO.MD.	
23. FUNERAL DIRECTOR'S SIGNATURE East Funeral Home Brownsville Md		ADDRESS Brownsville Md		24a. REC'D BY REGISTRAR Sept 19/57		24b. REGISTRAR'S SIGNATURE Katherine Daseh	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/55

BUREAU V.

SEP 23 1957

RECEIVED

9942

CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Maryland				c. LENGTH OF STAY IN 1b 50yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 334 N. Jonathan Street				d. STREET ADDRESS 334 N. Jonathan Street			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First George Middle Van Last Smith				4. DATE OF DEATH Month Sept Day 8 Year 1957			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar 6 1895	
9. AGE (In years last birthday) 62 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Upholster		10b. KIND OF BUSINESS OR INDUSTRY Auto body shop		11. BIRTHPLACE (State or foreign country) Williamsport, Md		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME James E. Smith				14. MOTHER'S MAIDEN NAME Florence V. Clark			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. World War 1 214-09-2799		17. INFORMANT Mrs Gladys Smith		Address 334 N. Jonathan St	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Insufficiency 023X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease and DUE TO Aortic insufficiency (rheumatic) (c) INTERVAL BETWEEN ONSET AND DEATH 15 min. 6 yrs. 12 yrs. certain hist. only							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. 18 , 19 51 , to Sept. 8 , 19 57 , that I last saw the deceased alive on August 27 , 19 57 , and that death occurred at 7:00 A.M. , from the causes and on the date stated above. D.S. ADDRESS (Street, city or town, state) DATE SIGNED 100 Professional Arts Bldg. 9-9-57							
ACTUAL SIGNATURE William T. Layman, M.D.		M.D. 100 Professional Arts Bldg. 9-9-57					
PHYSICIAN'S NAME (Type) William T. Layman, M.D.		Hagerstown, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept 11 1957		22c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		22d. LOCATION (City, town, or county) (State) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John R Watson Jr.				ADDRESS Hagerstown Md		24a. REC'D BY REGISTRAR Sept 11 1957	
				24b. REGISTRAR'S SIGNATURE Chas H Bowers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

9943

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY MARYLAND Washington				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 15 Mos			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Conv. Home				e. STREET ADDRESS 830 Potomac Ave			
3. NAME OF DECEASED (Type or print) First KATIE Middle LOUISE Last STALING				4. DATE OF DEATH Month Sept Day 26 Year 1957			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 26 1878	
9. AGE (In years last birthday) 79		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		11. BIRTHPLACE (State or foreign country) Rockingham Co Va		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Francis Staling				14. MOTHER'S MAIDEN NAME Amanda Nicewanger			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Address Mrs Julia Masters 830 Potomac Ave			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Arterio sclerosis DUE TO (c) Hypertension - heart block				INTERVAL BETWEEN ONSET AND DEATH 15 months Years Years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month 19 Hour a. m. p. m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from Jan 1955 to Sept 26 1957 , that I last saw the deceased alive on Sept 25 1957 , and that death occurred at 8:40 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 115 W. Wash. St Hagerstown Md DATE SIGNED 9/27/57							
ACTUAL SIGNATURE E. John D. Hoachlander				PHYSICIAN'S NAME (Type) E. John D. Hoachlander			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/28/57		22c. NAME OF CEMETERY OR CREMATORY Woodbine Cemetery		22d. LOCATION (City, town, or county) Va. (State) Harrisonburg Rockingham Co	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				24a. REC'D BY REGISTRAR Sept 28 1957		24b. REGISTRAR'S SIGNATURE Blair H. Bowers	

CERTIFICATE OF DEATH

Form with fields for Name, Sex, Age, Date of Birth, Date of Death, Cause of Death, and other medical details. The text is mirrored and difficult to read.

BUREAU V. 1

OCT 1 1957

RECEIVED

9944

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH o. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN				c. LENGTH OF STAY IN 1b 4 WEEKS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH.CO.HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) DR. JOHN HUBERT WADE				4. DATE OF DEATH SEPT. 21 1957			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH NOVEMBER 17 1872	
9. AGE (In years lost birthday) 84 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PHYSICIAN GENERAL PRACTITIONER		10b. KIND OF BUSINESS OR INDUSTRY BOONSBORO WASH.CO.MD.		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME ELI WADE				14. MOTHER'S MAIDEN NAME FRANCES HARPER			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-10-7030		17. INFORMANT MISS MYRA NYMAN BOONSBORO MD		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO 493x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) old age						INTERVAL BETWEEN ONSET AND DEATH 1 mo	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 8/20 , 19 57 , to 9/21 , 19 57 that I last saw the deceased alive on 9/21 , 19 57 , and that death occurred at 3:40 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown Md. DATE SIGNED 9/21/57							
22a. ACTUAL SIGNATURE J R Dwyer				22b. M.D. J R Dwyer MD			
22c. PHYSICIAN'S NAME (Type) J R Dwyer MD				22d. LOCATION (City, town, or county) (State) Hagerstown Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF SEPT. 23 1957		22c. NAME OF CEMETERY OR CREMATORY BOONSBORO MAUSOLEUM		22d. LOCATION (City, town, or county) (State) BOONSBORO WASH CO MD.	
23. FUNERAL DIRECTOR'S SIGNATURE East Funeral Home Boonsboro Wash. Co. Md.				24a. REC'D BY REGISTRAR 9/25/57		24b. REGISTRAR'S SIGNATURE Chad H. Bowser	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 3 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [REDACTED]		SEX [REDACTED]		AGE [REDACTED]	
RACE [REDACTED]		BIRTH DATE [REDACTED]		BIRTH PLACE [REDACTED]	
MARITAL STATUS [REDACTED]		OCCUPATION [REDACTED]		PLACE OF BIRTH [REDACTED]	
DATE OF DEATH [REDACTED]		TIME OF DEATH [REDACTED]		PLACE OF DEATH [REDACTED]	
CAUSE OF DEATH [REDACTED]		MANNER OF DEATH [REDACTED]		SIGNATURE OF PHYSICIAN [REDACTED]	
SIGNATURE OF REGISTRAR [REDACTED]		SIGNATURE OF WITNESS [REDACTED]		SIGNATURE OF DECEASED [REDACTED]	

RECEIVED
 SEP 27 1957
 BUREAU V. B.

9945

CERTIFICATE OF DEATH

09956

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Jackson Convalescent Home</u>		d. STREET ADDRESS <u>405 N. Potomac St.</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>AARON</u> Middle <u>A.</u> Last <u>Wagner</u>		4. DATE OF DEATH Month <u>Sept</u> Day <u>28</u> Year <u>1957</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 3, 1867</u>
9. AGE (In years last birthday) <u>90</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machenist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Machine, Tool</u>	
11. BIRTHPLACE (State or foreign country) <u>Ringgold, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob F. Wagner</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Manns</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>199-07-7115A</u>	
17. INFORMANT <u>Carroll H. Wagner</u>		Address <u>613 S. Potomac St. Waynesboro, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral vascular accident</u> DUE TO <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>arteriosclerosis</u> (c) <u>anemia</u>		INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u> <u>yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/25/57</u> , 19 <u>57</u> , to <u>9/28/57</u> , 19 <u>57</u> , that I last saw the deceased alive on <u>9/25/57</u> , 19 <u>57</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Howard N. Weeks</u>		ADDRESS (Street, city or town, state) <u>136 N. Potomac St. Hagerstown, Maryland</u>	
DATE SIGNED <u>9/28/57</u>			
PHYSICIAN'S NAME (Type) <u>Howard N. Weeks, M.D.</u>		<u>Hagerstown, Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/30/1957</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Waynesboro, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Walter G. Hine</u>		ADDRESS <u>Waynesboro, Pa.</u>	
24a. REC'D BY REGISTRAR <u>9/30/1957</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Bowers</u>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9946

CERTIFICATE OF DEATH

Reg. Dist. No. 09957302

1. PLACE OF DEATH o. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 2 mos.			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown				d. STREET ADDRESS 518 Washington Square			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Rest Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Paul Middle B Last Watlington				4. DATE OF DEATH Month 9 Day 6 Year 19 57			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 18, 1876	
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired				10b. KIND OF BUSINESS OR INDUSTRY Minister		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME unknown				14. MOTHER'S MAIDEN NAME unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Betty Watlington Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) General arteriosclerosis (c) Nephrosclerosis							INTERVAL BETWEEN ONSET AND DEATH 4 yrs.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec. , 1953, to Sept. 6th , 1957, that I last saw the deceased alive on Sept. 6th , 1957, and that death occurred at 7 A. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Philip J. Hirshman M.D. 9/7/57							
ACTUAL SIGNATURE Philip J. Hirshman M.D.							
PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D. 159 W. Washington St., Hagerstown, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 9-9-57		22c. NAME OF CEMETERY OR CREMATORY Woodlawn		22d. LOCATION (City, town, or county) (State) Baltimore Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss				ADDRESS Hagerstown, Md.		24a. REC'D BY REGISTRAR Sept. 10, 1957	
				24b. REGISTRAR'S SIGNATURE W. H. Bowers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

SEP 13 1957

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09958302

9947

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>W. Va</u> b. COUNTY <u>MORGAN</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>		c. LENGTH OF STAY IN 1b <u>16 HRS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASHINGTON CO. HOSPITAL</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERKELEY SPRINGS</u> 85x-3	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE HOLLIS INAUGH</u>		4. DATE OF DEATH Month Day Year <u>SEPT. 11 1957</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>SEPT. 9 1957</u>
9. AGE (In years last birthday) yrs. <u>2</u>		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>MORGAN Co., W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JESS W. INAUGH</u>		14. MOTHER'S MAIDEN NAME <u>VIRGINIA HUNTER</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>WM. H. HUNTER</u> Address <u>BERKELEY SPRINGS, W. Va.</u>	
17. INFORMANT <u>WM. H. HUNTER</u>		Address <u>BERKELEY SPRINGS, W. Va.</u>	
18. CAUSE OF DEATH [Enter only one cause on line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congenital Heart Disease - Transposition</u> <u>754.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>(Complete) of Great Vessels</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Morgellism</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/10/</u> 19 <u>57</u> , to <u>9/11/</u> 19 <u>57</u> , that I last saw the deceased alive on <u>9/11/</u> 19 <u>57</u> , and that death occurred at <u>9:30 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>A. M. Bacon Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>302 N. Potomac St</u> DATE SIGNED <u>9/11/57</u>	
PHYSICIAN'S NAME (Type) <u>Dr. A. M. Bacon Jr.</u>		<u>Hagerstown, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Reburial</u>	22b. DATE THEREOF <u>9/11/57</u>	22c. NAME OF CEMETERY OR CREMATORY <u>GREENWAY</u>	22d. LOCATION (City, town, or county) (State) <u>BERKELEY SPRINGS, W. Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ans. J. Hunter</u> ADDRESS <u>BERKELEY SPRINGS, W. Va.</u>		24. REC'D BY REGISTRAR <u>SEP 18 1957</u> 25. REGISTRAR'S SIGNATURE <u>Chas. H. Powers</u>	

CERTIFICATE OF DEATH

1957

Page No. 18

Form with multiple sections for recording death information, including fields for name, date, cause of death, and registrar details. The form is mostly blank with some faint handwriting.

BUREAU V. S.

SEP 18 1957

RECEIVED

OFFICIAL RECORDS

9963

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Hagerstown, Md.				c. LENGTH OF STAY IN 1b 43 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Route 6				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDNA Middle VIRGINIA Last WELTY				4. DATE OF DEATH Month Sept. Day 13 Year 19 57			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 1, 1897	
9. AGE (In years last birthday) 60 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife & Resturant Operator.		10b. KIND OF BUSINESS OR INDUSTRY Rockingham County, Va.		11. BIRTHPLACE (State or foreign country) U.S.A.	
13. FATHER'S NAME John W. Pittington				14. MOTHER'S MAIDEN NAME Evelyn			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 219-20-1886		17. INFORMANT Mr. Russell S. Welty R #6		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Embolism 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) 7 yrs.				INTERVAL BETWEEN ONSET AND DEATH Sudden			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aspiration				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan. 30 to Sept. 13, 1957 that I last saw the deceased alive on Sept. 13, 1957 and that death occurred at 10:30 A.M. from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED Sept. 16, 1957			
ACTUAL SIGNATURE Jack H. Beachley M.D.				22a. BIRTH, CREMATION, REMOVAL (Specify) Burial			
PHYSICIAN'S NAME (Type) Jack H. Beachley M.D.				22b. DATE THEREOF 9/16/57			
22c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery				22d. LOCATION (City, town, or county) (State) Hagerstown Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Cha pel Inc.				24a. REC'D BY REGISTRAR Sept. 16, 1957			
ADDRESS 1601 Penna. Ave. Hagerstown, Md.				24b. REGISTRAR'S SIGNATURE Phyllis Bowers			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

99960

9948

CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wash.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1001 Security Road</u>		d. STREET ADDRESS <u>1001 Security Road</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Caroline</u> <u>Yonger</u>		4. DATE OF DEATH Month Day Year <u>Sept. 1,</u> <u>19 57</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 17, 1888</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>Austria</u>	
13. FATHER'S NAME <u>Jon Tcharr</u>		14. MOTHER'S MAIDEN NAME <u>Maria Owolkavitz</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT <u>Miss Anna Yonger</u>		Address <u>Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Pre Pyloric Area</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept. 1, 1956</u> , to <u>Sept 1, 1957</u> , that I last saw the deceased alive on <u>Aug 31, 19 57</u> , and that death occurred at <u>7:15 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Robert V. Campbell</u>		ADDRESS (Street, city or town, state) <u>145 W. Washington St. Hagerstown Md.</u>	
DATE SIGNED <u>MD 9/2/57</u>			
PHYSICIAN'S NAME (Type) <u>Robert V. Campbell, M.D.</u>		<u>145 W. Washington St. Hagerstown</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>9-4-57</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Rose Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Scott F. Minnich & Son, Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR <u>Sept. 4, 1957</u>	
24b. REGISTRAR'S SIGNATURE <u>Phas H. Bowers</u>			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF DEATH		PLACE OF DEATH	
JAMES J. HENRY		39		Male		White		1937		Boston, Mass.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		MEDICAL ATTENDANT		CORONER	
1001 Washington St.		Carpenter		Heart Disease		Natural		Dr. J. J. Smith		John J. Smith	
BORN		DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARRIAGE		SIGNED	
1900		1900		Boston, Mass.		High School		Married		[Signature]	
FATHER		MOTHER		SIGNED		WITNESSES		CORONER		DECEASED	
James J. Henry		Mary J. Henry		[Signature]		[Signatures]		John J. Smith		James J. Henry	
FATHER		MOTHER		SIGNED		WITNESSES		CORONER		DECEASED	
James J. Henry		Mary J. Henry		[Signature]		[Signatures]		John J. Smith		James J. Henry	

RECEIVED
SEP 6 1937
BUREAU V. S.